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Evaluation of the Effectiveness of the Operation Restore Trust Demonstration

Contract No. 500-92-0014

Final Report: Executive Summary and Overview

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EXECUTIVE SUMMARY

Operation Restore Trust (ORT) was not the beginning of all wisdom in the fight against health care fraud. But when ORT began in 1995, there were major, visible threats to the integrity of the Medicare and Medicaid programs. Reports accumulated showing disturbing vulnerabilities in these programs — and showing laggard oversight and enforcement processes that failed to respond with seeming common sense. Thus:

- By all accounts, health care fraud and abuse were growing in volume and sophistication by the early 1990s.[1] Common sense suggested that more vigorous federal and state enforcement efforts were needed. Yet in the mid-1990s, the federal government cut key resources for combating fraud and abuse in health care.

- Investigators uncovered provider schemes showing glaring vulnerabilities in the structure of the Medicare program. But neither the people who discovered the weaknesses nor the agency primarily responsible for program policies (the Health Care Financing Administration (HCFA)) seemed to act with dispatch. There was no way for this inactivity to make sense to ordinary citizens or the press.

- Computer resources at a fairly modest level were in short supply in government enforcement agencies. Also in short supply were the resources and the will among agencies to share data that — when linked in even the most rudimentary ways — could identify aberrant patterns of provider behavior.

- Travel budgets in the regions — relatively small amounts of money — were being cut, and it is not clear that the previous amounts were adequate.[2] The result: providers fortuitously close to agency field offices received at least some attention, while remote centers of fraudulent activity (e.g., Miami) were barely touched.

- The agencies at the center of these programs and enforcement processes often seemed to act at cross-purposes. Indeed, some of them barely spoke to each other, except in a rigorously sequential form of collaboration, where each agency finished its work in relative independence, then passed the results along to someone else. Medicare contractors who were the first line of detection for much abusive behavior — they enroll most Medicare suppliers and pay all the claims — would speak of the Office of Investigations (OI) of the Office of Inspector General (OIG) as a "black hole."[3] In turn,

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1 For example, see U.S. House, Committee on Ways and Means, Subcommittee on Oversight, "Abusive Marketing Practices by Durable Medical Equipment Suppliers," Report, 102d 1st (1991), Report No. 5, U.S. House, Committee on Ways and Means, Subcommittee on Oversight, "Medicare Fraud and Abuse by Durable Medical Equipment Suppliers," Hearings, 102d 1st (1991), Serial 102-40, U.S. Senate, Committee on the Budget, "Waste and Abuse in Medicare Payments for Medical Equipment and Supplies," Hearings, May - November, 1991, and U.S. Senate, Committee on Finance, Subcommittee on Medicare and Long-Term Care, "Reducing Inappropriate Medicare Spending," Hearings, 102d 2d (1992)

2 Consider: from FY 1992 to FY 1995 (roughly, the beginning of ORT), travel funds for HCFA alone in Region 9 (San Francisco) increased from $443,089 to $579,397. In FY 1996, travel funds were cut to $371,155, excluding ORT funds. ORT funding thus arrived just as travel funding was being otherwise cut

3 Interview by Abt Associates staff with a Medicare contractor, circa 1993

investigators, auditors, and others were puzzled as to how HCFA and its contractors could so readily enroll suspicious providers and so readily pay sometimes bizarre claims.

Never mind the outside observers in the public, the press, and Congress. To inside observers with a front-row seat — experienced staff in the Inspector General's Office, HCFA, its contractors, and others — the process seemed *to fail to act purposefully* in critical ways.

ORT was an effort to change that — most of all to bring more common sense and purposefulness to enforcement efforts. In that effort, the Department of Health and Human Services (DHHS) brought more resources to fraud enforcement, reversing trends of the preceding few years. But what is interesting is what DHHS did not do in ORT: it did not launch a broad program to take on all of these problems at once. Instead, DHHS developed a targeted set of initiatives designed to take on a few states, a few areas of the Medicare benefit, and a few of the more frustrating standard operating procedures (especially, failures to coordinate among the most central agencies and to exploit available data resources). By being careful in what it took on — and pursuing intensely those few things — DHHS avoided dissipating its efforts and resources.

Based on the results, we conclude that DHHS chose wisely. ORT can fairly be said to have turned around the troubling trends of the early 1990s and — in step with other efforts by the OIG, HCFA, the Department of Justice, and others — to have brought new vigor to government efforts to combat health care fraud and abuse. We have concluded a two-year evaluation of ORT. Our results show that ORT had important effects across the full spectrum of organizations it sought to affect, and even had some important effects on organizations over the boundaries of the demonstration (e.g., Medicare contractors) that were not so directly orchestrated by the ORT initiative. Specifically, we find:

1. ORT was associated with a net increase of over 100% in ORT-type cases investigated by the OIG's Office of Investigations. The increase in cases was particularly large for home health and DME, much smaller for nursing homes. Case initiation became more collaborative, there is some evidence that cases were of higher quality, and there is also evidence of more active agent follow-up to cases. There meanwhile was little evidence of a diversion of investigative resources from non-ORT targets, a result that suggests the wisdom of adding substantially to OI staff at the outset of ORT.

2. These ORT cases should generate substantial *incremental* receivables totaling $117.7 million. Some fraction of those receivables will translate into true savings as collections are made. Incremental collections as of May 1997 are estimated at $4.6 million, but we expect ultimate recoveries to be much larger. At the same time, even cases that yield no collections (e.g., due to provider bankruptcies) will yield at least some new cases of exclusion, suspension, and disruption of unscrupulous providers due to the effects of ORT. These latter effects are an important benefit to the program, by themselves.

3. The ORT effect on audits conducted by the OIG's Office of Audit Services (OAS) has been similarly substantial. For example, the volume of ORT-type audits increased over 1000% (on an annual basis) for all ORT subject types, compared to the 1990 - 1994 period. It is difficult to estimate the savings from these audits, since the needed data will not be available until certain audits have moved forward in the judicial process. But we

have no reason to believe these savings will not be substantial. Meanwhile, there is ample evidence that ORT resources were especially important to OAS, and that ORT represented a substantial innovation in approach for OAS (more provider-specific, more data-driven audits, at a more significant geographic reach).

4. HCFA and its contractors had a series of successful projects under ORT, with notably large collections or avoidances of payment accompanying many of these efforts. We cannot say with confidence that these are in each case true ORT savings, since (due to data limitations) we cannot be sure that savings of comparable magnitude would not have been realized in the absence of ORT. This is an important qualification, since activities of the contractors began to increase substantially in intensity before ORT, in apparent response to earlier HCFA initiatives. In other words, *pre-ORT* initiatives are responsible for some of the observed change in HCFA and contractor activity, so it is notably difficult to sort out what is attributable to ORT and what is not. It is in any event true that the activities of HCFA and its contractors played an important part in ORT, even if the incremental effects of these new activities cannot be estimated with precision.

5. Operation Restore Trust encouraged several important policy changes that were made during, or immediately following, the demonstration. Attribution of causal influence is complex, however. The existence of ORT resulted from strong beliefs at the highest levels of the federal government that more had to be done about health care fraud and abuse, and those same beliefs also prompted some of the policy changes. The focus of ORT on specific problem areas in specific states certainly helped build the body of evidence that led the Administration and the Congress to act — but so did the intensified efforts of the FBI and DOJ. While it would be an error to give full credit to ORT for the unusually active period of policy changes regarding fraud and abuse in 1996–1997, it also appears true that ORT made an important contribution to those changes.

   Thus, in certain relatively narrow examples — e.g., changes in Medicare rules affecting independent physiological laboratories and the compounding of medications — ORT was clearly the driving force behind the changes. Other, broader, and more important initiatives were certainly helped along by identifiable products and results from Operation Restore Trust, but the contributing factors are more numerous and diffuse. Examples are tighter control of DME provider numbers, the moratorium on new Medicare HHAs announced by the President in September 1997, the provisions in the Balanced Budget Act of 1997 to require surety bonds of some providers, and the new funding for anti-fraud efforts in the Health Insurance Portability and Accessibility Act of 1996.

6. We found evidence that ORT may have had important "sentinel effects" -- i.e., ORT may have deterred providers from certain kinds of suspect behavior. Using our standard double-difference model of ORT effects (i.e., estimating the differences in ORT states compared to non-ORT states and the pre-ORT period), we cannot say with confidence that ORT had sentinel effects, because the effects are not statistically significant at conventional levels. However, they are consistently negative (i.e., ORT was associated with a consistent decrease in allowed charges) for home health and DME outside nursing

homes. The fact that they are consistently negative suggests that *something* important was going on, even if there is too much statistical noise for us to pick it up.

During the ORT period, a whole array of government initiatives were implemented to combat fraud and abuse in the Medicare program. These initiatives included many efforts with nationwide impact (e.g., stepped-up enforcement efforts by the Department of Justice and the FBI, major HCFA initiatives with Medicare contractors, and others). These efforts contributed to a large nationwide decrease in allowed charges for home health and DME, and a smaller decrease for DME in nursing facilities. The models used to estimate sentinel effects do not allow us determine how much of the nationwide decrease in allowed charges was due to ORT spillover effects (i.e., effects associated with ORT on provider behavior in non-ORT states) and how much was due to other programs and time factors that would have occurred even in the absence of ORT.

7. We found considerable process effects in ORT. Specifically, we found:

- The ORT partner agencies are collaborating more closely on fraud and abuse issues than in the past.
- Evidence of this collaboration is wide ranging and includes substantial initiatives between OI and OAS, federal regional officials and state agencies (e.g., federal and state survey staffs), regional agencies and Medicare contractors, and others.
- The integration of different skills on the same team—such as those of nurses and auditors—has been a major accomplishment of ORT, due in part to the presence of discretionary resources and in part to the philosophy of inter-agency engagement.
- HCFA contractors saw ORT as a positive influence on the work of the regions. But for these contractors, the big change of the past few years has been HCFA's restructuring of the program integrity functions of the contractors. In some cases, these restructurings have led to notable changes in carrier operations and (possibly by coincidence) notably active collaboration with ORT projects.

8. Giving the Administration on Aging (AoA) a fraud and abuse mission was a good idea and led to active training, outreach, and education efforts. But the effects of these activities on such outcomes as referrals and cases are not well measured, and key parts of the process (e.g., feedback of results to ombudsmen) are not yet fully worked out.

9. The work of OIG's Office of Evaluation and Inspection (OEI) generally changed in only minor ways (e.g., reorientation of studies to include somewhat greater emphasis on ORT states and subjects). But ORT brought selected instances of more comprehensive and intensive studies that better equipped others for investigation and policy revision (as in the drug/nebulizer studies performed by OEI staff in the Philadelphia regional office). ORT also enabled one region (Dallas) to demonstrate an alternative role for OEI, bringing genuine in-house analytic sophistication to the targeting of enforcement efforts, notably

through development of a major Medicare-Medicaid nursing home data base. Finally, the collaboration of ORT brought OEI central office more systematically into policy-making networks — from which OEI had been more distant than it realized.

10. The infrastructure of information for combating fraud and abuse has been significantly improved during ORT, although these improvements include many efforts outside ORT itself. The HCFA Customer Information System, the Fraud Investigation Database, and other information systems and computer resources will provide important capabilities that were not available before. Meanwhile, new estimates of the prevalence of fraud and abuse are being developed. Specifically, as required under the Government Management Reform Act (GMRA) of 1994, OAS has completed a major audit of Medicare claims to provide an estimate of the underlying rates of improper payments (improper payments include fraud and abuse, but also insufficient documentation and other problems).[4] GMRA requires this audit to be performed annually. The availability of annual estimates of improper payments will make it easier to determine underlying trends in fraud and abuse, to establish more definitive sentinel savings for enforcement efforts (estimates that take into account provider responses), and to establish more data-driven allocation of enforcement energies. Such information would be a major step forward.[5]

11. ORT included a series of national initiatives not exclusively confined to the ORT states: an enhanced OIG hotline, a new Voluntary Disclosure Program, and wider use of special fraud alerts. Each of these initiatives makes sense as part of a modern program integrity effort. However, none of these initiatives was crucial to the effects of ORT.

On balance, this list of effects is a record of substantial accomplishment. It is too soon to say what the ultimate benefits will be from ORT. Exhibit E-1 below summarizes what we believe can be stated at present about the relationship of costs and monetized benefits in ORT. Obviously, there is considerable uncertainty about key results. But beneath all of the qualifications and data limitations noted on the exhibit and in the report that follows is a story of substantial success. At a minimum, we can say that, at any collections rate over 12% on remaining receivables , savings from *OI cases alone* are likely to cover even our highest estimate of ORT costs ($18.9 million). At any substantial collections rate, *the savings from OI cases alone will cover ORT costs many times over.* Meanwhile, the savings from other sources are also likely to be substantial: i.e., from OAS audits, HCFA and contractor activities, policy changes, and sentinel effects. The fact that we are unable to estimate savings from all of these activities does not mean that we expect zero savings in each case. Indeed, the results are likely to be positive in each case and are potentially quite large.

In the future when better data are available, it may be useful to develop a more exact estimate of the ratio of ORT benefits to ORT costs. But data available now already give an answer to the most important

4 DHHS/OIG, "Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996" (A-17-95-00096, July 1997)

5 It is important to note that, at some point, if government enforcement efforts have sizable deterrent effects, the level of fraudulent activity should decline, and with that decline, there might well be a decline in the number of cases being brought. The best way to know why that decline had occurred would be through analyses of time series data on improper payments, such as OAS is developing. Without such data, there would be no way to know whether the decline in cases was due to lower rates of misbehavior by providers or less effective enforcement methods by the government and its contractors.

analytic question, concerning the overall relationship of costs and savings in the ORT demonstration. Even using fairly conservative assumptions — and even at this early date in the maturing of cases, audits, and other key activities that will actually produce the savings — we expect the savings from ORT substantially to exceed the costs.

Thus, while it is too soon to offer definitive estimates of the savings attributable to ORT, it is fair to say that information now available documents results that most ORT partners would have welcomed in the beginning. To most observers — excepting significant portions of the provider community — ORT has been a notable success. Indeed, that result has been formally asserted: the Secretary of DHHS has announced the extension of ORT methods nationwide, with an initial focus on 12 additional states. In addition, DHHS anti-fraud efforts received major new resources and enforcement authority in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and additional enforcement powers in the Balanced Budget Act of 1997.

We generally agree with the favorable appraisals of ORT — indeed, in areas like our sentinel estimates, we believe that the general consensus might understate what ORT (in combination with other government initiatives) has accomplished. The challenge for the future will be to sustain and enlarge these accomplishments. This challenge is important because, in our judgment, *the considerable accomplishments of ORT were achieved under very special circumstances*, including:

1. Focus on a few states and a few areas of the benefit — Rather than attack fraud and abuse in a broad, undifferentiated way, ORT contained a set of deliberate limits (most important, five states and three fast-growing areas of the benefit). ORT opted for high impact in a few areas, rather than risking slight impact across a larger canvas. It will be a challenge to maintain the advantages of such focused efforts, now that ORT is being expanded and extended.

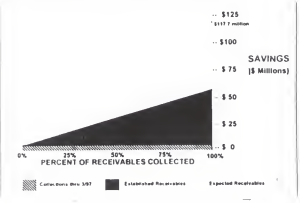
2. An infusion of resources — ORT provided a special infusion of financial resources that gave ORT regions more discretion to pursue promising activities. In addition, in a move technically separate from the ORT budget, DHHS increased investigative staff in the ORT states by 43%, along with certain other OIG staff additions. These added staff resources were important to what ORT accomplished.

   After most demonstrations, it is difficult to sustain the special increases in spending (and other resources) that the demonstrations brought — especially when the demonstration is, as here, being expanded. But after ORT, under the new arrangements authorized by HIPAA, resources should be available to support an expanded effort to identify and investigate health care fraud and abuse.

3. More active collaboration — Under the "partnership" approach of the ORT demonstration, ORT encouraged the partner agencies and others to collaborate actively and informally, rather than in the more isolated, sequential ways of the past. This encouragement was backed by ORT resources, high-level attention, and other means. While no one can measure the gains from collaboration in any precise way, everyone saw collaboration as a key to ORT accomplishments. We were offered innumerable small and large examples of how such collaboration improved the work of each of the agencies.

Exhibit E-1. Evaluation of ORT: Summary of Costs and Potential Savings

TYPE OF COST	AMOUNT
DIRECT COSTS	
– Activities funded out of the Medicare Trust Fund (excluding evaluation)	$6.9 million
– 29 additional OIG staff, largely OI investigators, devoted to ORT	$3.0 million
Subtotal	$9.9 million
INDIRECT COSTS	
– OAS staff devoted to ORT audits	$5.5 million
– Cost of other HCFA, OIG, and AoA staff	$3.5 million
Subtotal	$9.0 million
ORT COSTS =	$9.9 - $18.9 MILLION

TYPE OF SAVINGS	AMOUNT
DIRECT CASE SAVINGS from incremental effects of ORT on investigations	Some fraction of $117.7 million in additional receivables associated with ORT cases
– Recoveries ($4.6 million by end of ORT)	
PLUS	
– Future collections from $113.1 million in established + expected future receivables (collection rate unknown)	
OTHER DIRECT SAVINGS that cannot be estimated as of July 1997 (e.g., no data yet)	
– HCFA and contractor activities	? million
– OAS audits	? million
Subtotal	? million
INDIRECT SAVINGS that are difficult or impossible to estimate (e.g., data not adequate)	
– Policy changes	? million
– Possible sentinel ("deterrent") effects	? million
Subtotal	? million
ORT SAVINGS =	? MILLION

SOURCE: Abt Associates Evaluation of Operation Restore Trust: Final Report (1997), based on data thru March 1997 (for costs and collections) and May 1997 (for receivables)

It will be a challenge to maintain this collaboration after ORT is over. Both headquarters and regional staffs say that old ways of doing business cannot return, because ORT (and their own considerable experience) has shown that those old ways do not make sense. Indeed, planning efforts for HIPAA and ORT continuation were more collaborative than pre-ORT efforts. But these planning efforts were not as clearly collaborative as ORT itself. The struggle to keep barriers low among the partner agencies will be a continuing struggle and will require extensive continuing efforts at all levels of DHHS. The outcome of that struggle remains to be seen.

4. High-level attention and the "ORT priority" — High-level attention was a fundamental part of the energy behind ORT, and an important reason that bureaucratic walls could be lowered. The demonstration was announced by the President, overseen by the Secretary of DHHS (through her Chief of Staff), and managed by a Special Advisor to the HCFA Administrator for Program Integrity. High-level oversight meetings were held bi-monthly (later quarterly) among the partner agencies, under DHHS auspices. Regional ORT teams met once a month (typically by teleconference) with the Special Advisor, who was in a position to withhold ORT funds from regions that failed to develop satisfactory plans. In view of all of these different avenues of pressure and visibility, it is not surprising that one could get immediate attention for an ORT-related project by simply making the ORT relationship known.

   Now that ORT is over, there is still considerable high-level attention, but it will be a challenge to maintain this kind of priority. The extension of ORT must mean some reduction in the focus that was important to the accomplishments of the demonstration. At the same time, in HCFA at least, oversight of these activities has been moved down in the organization, although (as part of HCFA's more general reorganization) the Special Advisor does have dotted-line reporting authority directly to the Administrator. Meanwhile, the frequency of high-level oversight meetings among the partner agencies has declined — something that was bound to happen, if for no other reason than that scarce high-level attention would have to be spread among an expanded set of regions.

   In thinking about the likely effects of these changes, the experiences of the comparison regions we studied are instructive. Staff in these non-ORT regions have attempted many thoughtful initiatives. In the words of the staff responsible, such initiatives are feasible even without ORT-style priorities. But in the absence of some means to prompt immediate attention, these non-ORT initiatives have required extended effort to accomplish simple things—e.g., to get a contractor and a state agency together to pursue some kind of data match. That is the kind of difficulty that ORT seems to have solved. The ORT priority cut through ordinary inertia. The challenge after ORT will be to maintain the sense of urgency ORT succeeded in creating.

5. A set of reinforcing initiatives by other agencies — ORT did not exist in a vacuum. ORT efforts were supported and reinforced by a whole array of government initiatives, including HCFA initiatives with Medicare contractors (establishment of the DME Regional Carriers and the specialization of program integrity contracts), new powers in legislation from Congress (e.g., HIPAA), major DOJ initiatives (e.g., expansions of

health care task forces and funding of Assistant U.S. Attorneys specializing in health care fraud cases), and others. These generally complementary efforts had important effects on what we observed under ORT.

Most important federal actors in this process have made commitments to give health care fraud and abuse a continuing high priority. These commitments will be needed to support future activities along the lines of what ORT achieved under exceptional circumstances.

We believe that the accomplishments of ORT can indeed be extended and expanded in a form approximating what ORT itself accomplished. Many of the preconditions for continued success are in place — most importantly, in terms of funding, personnel, and new statutory authority unthinkable even a few years ago. The key questions now concern whether 1) an expanded effort — for all its virtues — will lose the advantages of refracted attention, attention that will now be dispersed across a broader area, and 2) whether the continuing commitments in DHHS and elsewhere will suffice to keep bureaucratic barriers down, so that agencies that are extensively interdependent in principle will continue to collaborate extensively in practice.

Organization of the Study

These conclusions are developed in the summary report that follows and in the 11 appendixes that provide detailed analytic results to support our conclusions. This summary report is divided into 10 chapters:

1. The ORT Demonstration — an overview of the demonstration, to identify ORT objectives and the full range of ORT interventions.

2. Overview of the Evaluation — a summary of the principal data and methods of the evaluation.

3. The Costs of ORT — a set of estimates of the different costs of ORT.

4. Findings of the Evaluation 1: The Effects of ORT on OI Cases — estimates of the volume, character, and outcomes of cases under ORT, including alternative estimates of likely savings attributable to ORT effects on cases.

5. Findings of the Evaluation 2: The Effects of ORT on OAS Audits — estimates of the volume, character, and outcomes of audits under ORT.

6. Findings of the Evaluation 3: The Sentinel Effects of ORT — estimates of sentinel effects in key areas of ORT activity, to explore possible continuing effects of ORT initiatives.

7. Findings of the Evaluation 4: The Effects of ORT on Processes of Enforcement — a review of qualitative and quantitative data on the effects of ORT on processes of detection and enforcement, including the success of the partnership model, changing impetus for initiating cases and enforcement actions, and effects on processes of policy change, as well as specific discussions of ORT effects on OEI, AoA, HCFA, and the other ORT partners.

8. Findings of the Evaluation 5: Hotline, Voluntary Disclosure Program (VDP) and Special Fraud Alerts (SFA) — a discussion of the results of these special, ORT-related projects.

9. Comparing the Costs and Savings of the ORT Demonstration — a summary of the comparative size of costs and benefits in ORT, based on alternative assumptions about the costs and savings that should be included.

10. Implications and Future Prospects — the summary judgments of our evaluation, including concerns about how and whether ORT can be expanded and sustained.

This is a complicated set of results, reflecting our judgment that the only way to evaluate ORT is by using a multiplicity of different approaches and datasets. Across all of these different approaches and datasets, the key issue for the evaluation has been to see if the results tell a roughly consistent story. To a striking degree, these results do tell such a story, which gives us increased confidence in the conclusions that follow.

FINAL REPORT: OVERVIEW AND IMPLICATIONS

Chapter 1
THE ORT DEMONSTRATION

Operation Restore Trust (ORT) was a demonstration to target provider fraud in nursing homes, home health care services (including hospice care), and durable medical equipment. Five states—California, Florida, Illinois, New York, and Texas—were included in ORT. These states together accounted for 40% of Medicare expenditures before ORT began. The ORT demonstration officially started April 1, 1995, and ended March 31, 1997.

ORT combines the efforts of three agencies within the U.S. Department of Health and Human Services (DHHS) — the Office of the Inspector General (OIG), the Health Care Financing Administration (HCFA), and the Administration on Aging (AoA) — and several other federal and state agencies, including the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), United States Attorney's Offices (USAOs), long-term care ombudsmen, state units on aging, Medicaid fraud control units (MFCUs), and Medicare contractors.

1.1 Objectives of Operation Restore Trust

The mandate for the partner agencies was ambitious. There were five principal objectives:[6]

- To identify, investigate, and penalize entities willfully defrauding the Government — The first objective was to step up enforcement efforts in the most direct way, by targeting ORT-type and ORT-state providers for identification, investigation, and penalties. These stepped-up efforts were not to be mere expansions of old ways of doing business, however. These new efforts were to be:

  - more data driven, making more refined use of statistical techniques, data matches, and other methods to identify subjects for investigation.

  - more collaborative, using a process of deliberate information sharing and cooperation among partner agencies and others.

  The underlying vision here was to increase information resources and to break down bureaucratic barriers, to establish more efficient targeting and case and audit development.

- To alert the public and the industry to health care fraud schemes — A second objective was to encourage compliance by reducing uncertainties about what compliance requires and to raise awareness of specific and general threats of enforcement, to deter abuse. The

6 DHHS, "Operational Plan: Health Care Anti-Fraud Demonstration Project," undated.

mechanism for providing this information was to be OIG special fraud alerts, as developed and refined collaboratively through the ORT project team.

- To identify problems of noncompliance with existing statutes and regulations — The third objective was to perform a series of cost report audits, focused audits, analyses, and other reviews of specific areas of suspected noncompliance with home health, nursing home, and DME requirements. The ultimate purpose of these efforts was to intensify the identification of noncompliance with existing statutes and regulations. For example, the OIG planned to conduct a series of cost report audits to assess the accuracy of general and administrative costs claimed by providers on Medicare cost reports. It also planned to perform an assessment of the nature and appropriateness of services (DME, mental health, and other) associated with Medicare nursing home stays.

- To identify systemic problems relating to program effectiveness and efficiency and vulnerabilities to fraud and abuse — The fourth objective was to identify systemic problems with the Medicare benefit for ORT-type services. This objective was similar to the third objective above, but with a more explicit mandate to use systematic problem-identification to improve policy — i.e., to identify ways that program policies and practices could be improved, to increase effectiveness and to reduce fraud and abuse. ORT planners envisioned a set of projects by each partner agency for each type of provider. These projects were to be conducted as part of an overall assessment of potential waste, inefficiency, and systemic vulnerability to fraud and abuse. For example, the OIG was slated to perform provider-specific analyses of home health costs and visits to beneficiaries, to identify agencies with high costs per beneficiary. HCFA planned to implement a project to identify home health agencies with possible abuses and to support state agencies in performing extended reviews of those agencies.

- To allow providers to voluntarily disclose evidence of fraud that they have uncovered in their own organizations — ORT contained a pilot Voluntary Disclosure Program (VDP) to fortify efforts in identifying targets for fraud and abuse investigations. VDP would allow providers to self-disclose matters involving Medicare fraud and abuse and thereby would elicit greater industry participation in the detection and prevention of Medicare fraud and abuse.

The activities outlined above were to be funded in a novel way: by drawing on the Medicare Trust Fund, as a prototype of a "reinvestment fund" that would provide a longer range solution to the funding of fraud and abuse activities.[7] Fraud and abuse enforcement activities had been reduced in the first half of the 1990s, even as DHHS' oversight responsibilities had expanded. Budget-balancing pressures and legislation made any expansion of enforcement activities difficult. By linking the funding of enforcement activities to the returns from enforcement efforts — returns that promised to exceed the funds invested — DHHS and the partner agencies sought a more stable long-run foundation for stepped-up enforcement, amidst the stringencies of the existing budget climate.

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7 The transfer from the Medicare trust funds was possible because of a provision in Medicare statutes (42 U.S.C.A. 1395b-1(a)(1)(J)) that allows the Secretary of DHHS to use trust fund money to develop or demonstrate improved methods for investigating or prosecuting fraud. Operation Restore Trust was the first time this sub-paragraph had been invoked.

1.2 What Is "the ORT Intervention"?

If the above summary defines ORT in formal terms, it only begins to describe what ORT represents as an intervention. We see the defining characteristics of the ORT intervention as follows.

First, ORT represented a focused, deliberately limited intervention. Rather than attack fraud and abuse in a broad, undifferentiated way, ORT contained a set of deliberate limits. The most important limits were in:

- *Geographic areas*: ORT could have been a nationwide effort. Instead, ORT focused on only five states (the five largest Medicare states),[8] with only incidental spillage of efforts into other geographic areas.

- *Types of providers/suppliers*: For the five states selected, ORT could have taken on fraud where fraud was found, or focused on big ticket items (e.g., hospital expenditures) that might actually have provided a larger return in a narrow financial sense. Instead, ORT represented a deliberate choice to focus on three fast-growing areas (DME, home health/hospice, and skilled nursing facilities) to the virtual, if not complete, exclusion of others. These three areas were not the only places where abuses could be found in the Medicare world. But they were thought to be notably under-monitored in the past and disturbingly vulnerable to unscrupulous providers. In that sense, ORT represented a decision to attack areas that were viewed as large threats to program integrity, even if they were not the areas promising the largest dollar return to enforcement efforts.

This kind of self-limitation represented a prudent decision, particularly in light of fears that a broader focus would dissipate efforts and resources and result in little ultimate impact. ORT opted for high impact in a few areas, rather than risking slight impact across a wider area. As sensible or natural as this choice seems, it was not easy. There were centrifugal forces from the beginning, pressing to expand the demonstration's agenda to other areas and types of providers.

Second, in the focused areas selected for cultivation, ORT represented an infusion of resources. These resources went to the DHHS regions and, to a lesser extent, to certain central office activities. The direct, formal ORT budget was $7.9 million over two years. Actual spending that could be traced to ORT activities was $7.6 million. Approximately 40% of the $7.6 million was for travel, including funds explicitly designated for travel and funds given to states largely to cover the travel expenses of state surveyors. Other funds were used to change the geographic presence of agencies: e.g., the rental of warehouse space in Miami, the HCFA satellite office in Miami, and the OIG satellite office in southern Illinois. Funds were also used to upgrade computers and to acquire specialized support and other equipment (e.g., in California, to acquire electronic equipment to monitor an undercover operation and computer tapes to facilitate the seizure and copying of records). Funds generally did not go to Medicare contractors, although there were incidental exceptions when contractors did particularly intensive work (e.g., reimbursement of the regional home health intermediary (RHHI) for travel costs associated with

8 In Fiscal Year 1995 (the beginning of ORT), these five states were the largest Medicare states in terms of estimated total benefit payments. See Health Care Financing Administration, 1996 Data Compendium (Baltimore: Health Care Financing Administration, March 1996), p. 107.

home health audits in Texas and reimbursement of the Durable Medical Equipment Regional Carrier (DMERC) for costs associated with extensive computer runs for California).[9] No funds went to federal agencies outside DHHS.

At the same time, 29 new personnel were added to the OIG, 24 of them in the Office of Investigations (OI). Annual cost of this new staffing was about $1.5 million. Although the cost was not paid from the ORT budget, the new staff were dedicated to the ORT effort.

Third, ORT represented the deliberate introduction of the partnership model into the activities of the regions. ORT not only proposed to augment certain staffs and to provide them with added resources. It also proposed to organize the enforcement process somewhat differently. A key premise of ORT was that results would improve if agencies worked together more closely. This was a sharp change from the past. Various people described HCFA and OIG as traditionally distant, with HCFA viewing fraud as OIG's responsibility and OIG wary of infringements on the independence it traditionally had. Within OIG, OI and the Office of Audit Services (OAS) were said to work separately, with little active coordination early in audits or cases. Coordination and collaboration was done in sequence. OAS might do a lengthy industry study, then pass on a particular lead to OI for investigation, which itself could take months or years. OIG then might recommend to HCFA a change in policy to prevent broader recurrence. Such discrete steps appear to have been the rule rather than the exception. AoA, meanwhile, had no traditional role in deterring fraud and abuse in the Medicare program. ORT represents an effort by senior management in all of the partner agencies to try to break down these barriers.

Fourth, ORT represented the introduction of innovative methods of detection, audit, and investigation, beyond the general collaboration of the partnership model. Aside from increased co-operation with other agencies, individual offices sought to pursue new approaches under ORT. For example, for HCFA and OIG, ORT was used to underwrite more data-driven processes of identification of suspect providers — e.g., using claim and audit records to provide proactive identification of targets, rather than waiting passively for referrals or complaints. Meanwhile, ORT expanded the range of sensors available to detection efforts, notably by using long-term care ombudsmen to spot suspicious activity. Individual ORT participants sought to change their conventional ways of doing business: e.g., OAS sought to do more audits to identify and appraise provider-specific fraud, and OI attempted to work more collaboratively at earlier stages of cases to expedite identification and investigation of suspicious activity. Meanwhile,

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9 At the outset of ORT, a total of $0.3 million was budgeted for Medicare contractors. It may be useful here to give a brief description of the DMERCs and of two associated changes implemented by HCFA: the "SADMERC" and the National Supplier Clearinghouse. DMERCs — There are four DME Regional Carriers, representing a consolidation into four regions of the carrier activities formerly performed as a component of the much larger Part B carrier responsibilities of more than 50 Part B carriers. Each DMERC is responsible for processing Medicare claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in its respective region of the U.S. and for the implementation of more active program integrity activities focused on DMEPOS. SADMERC — SADMERC is an acronym for statistical analysis durable medical equipment regional carrier. The SADMERC is one of the DMERCs that has been contracted by HCFA to collect, store, and analyze DMEPOS claims history data from all regions and issue reports on the utilization of these items and services to the DMERCs and HCFA. The SADMERC was designed to provide more sophisticated reporting and analyses of DMEPOS costs and utilization, to identify outlier suppliers and suspect utilization trends. National Supplier Clearinghouse — The NSC is the DMERC that has been contracted by HCFA to perform the enrollment function for DMEPOS suppliers in the Medicare program. Though the NSC, HCFA sought to centralize data collection on provider enrollment and to add certain data elements to the DMEPOS provider enrollment process (e.g., data concerning ownership). The NSC data was expected to enhance the capabilities of the DMERCs and the SADMERC to analyze provider characteristics for program integrity purposes. Note that the same DMERC (Palmetto) currently serves as both the NSC and the SADMERC.

DHHS, and particularly the AoA, put considerable effort into informing beneficiaries, advocates for the elderly, and the public generally about fraud and abuse.

Fifth, ORT brought unprecedented high-level attention and a claim of priority to fraud and abuse efforts. This aspect of ORT is difficult to measure, but it may represent the most important special condition of the demonstration. It is clear that officials in DHHS made Medicare fraud and abuse a priority, with ORT the vehicle for much of that concern. The tangible evidence of this priority suffuses all that ORT did. ORT was announced by the President on May 3, 1995. It was a special priority of the Secretary of DHHS (e.g., to monitor ORT progress, bi-monthly (later quarterly) meetings were held under the direction of the Secretary's Chief of Staff, with senior staff from the Office of the Secretary, OIG, HCFA, AoA, and others in regular attendance). The attention given to ORT by senior management at HCFA, OIG, and AoA was unusual, to say the least. In HCFA, coincident with the very early development of ORT in 1994, the HCFA Administrator appointed a Special Advisor for Program Integrity, Judy Berek, a senior official reporting directly to him who was effectively the project director for ORT. This senior appointee controlled the ORT budget and had direct access to the Administrator. This new arrangement placed program integrity in a position of unprecedented leverage.

This high-level attention reached into the interstices of ORT activities. ORT teams in each region held regular teleconferences with the HCFA Special Advisor. Organizations that were not formally part of ORT — e.g., Medicare contractors, U.S. attorneys, and FBI field agents — understood that ORT business was the first priority of DHHS. As it was put in one of our interviews in the ORT regions, ORT business "always went to the head of the line." Thus, indictments were obtained more quickly in ORT cases than in non-ORT cases. Meanwhile, it was also clear that, where ORT did not provide resources, it did provide the justification (indeed, effectively, the requirement) for staff to set aside or delay other work to focus on ORT business.

Sixth, ORT represented a slightly different set of priorities in each region. ORT was not a homogeneous intervention, with only the vagaries of context and implementation to cause small differences across the five regions. It was, deliberately, a different program in each region. Within the overall requirement to target home health, nursing home, and DME services and the overall budget and staffing decisions that were made centrally, each region was given some discretion to develop its own program infrastructure and priorities. This latitude constituted an understandable adaptation to the problems of each region, but it also complicates extensively the specification of precisely what ORT is. It means that ORT was five different clusters of interventions, notwithstanding all the similarities (and the deliberate borrowing and emulation) that occurred across ORT regions.

Seventh, at the national level, ORT included a set of specific national program initiatives to support fraud and abuse efforts generally. These national initiatives were part of the main ORT effort. There were three such initiatives:

- the OIG hotline, which supports DHHS programs generally.
- the Voluntary Disclosure Program (VDP), which accepted applications from Medicare providers of all kinds and from all geographic areas who came forward voluntarily to report possible instances of fraud and abuse.

- special fraud alerts (SFAs), which provide notice and advice to providers, beneficiaries, and contractors about specific problems of coverage, billing, and related issues.

These initiatives are ORT-related only in that they provide important support to efforts to combat Medicare fraud and abuse generally. But they were not targeted on the five ORT states nor were they targeted exclusively on home health, nursing home, and DME services.

Finally, from the local level to the national level, ORT was not the only effort to rejuvenate enforcement processes against health care fraud and abuse. ORT was a discrete enterprise, but it can be viewed as an expression of a much larger movement. At the local level, for example, there were various smaller-scale efforts, such as health care anti-fraud task forces. At the national level, most of the major organizations in fraud and abuse enforcement were undertaking new initiatives:

- HCFA efforts to reorient its carriers and intermediaries — In the early 1990s, HCFA gave strategic guidance to its Part B carriers, emphasizing that they would have to begin developing major analytical capacities. Specifically, carriers were to "acquire a different mix of personnel...[including] appropriate skills in statistics, data analysis, and trend analysis..."[10] These changes in strategic guidance were soon followed by more substantive changes. For example, beginning in 1993, responsibility for processing DME claims was consolidated into four DMERCs, along with a special supplier certification process (the National Supplier Clearinghouse) and a special statistical analysis effort by one of the DMERCs (the Statistical Analysis DMERC, or SADMERC).[11] By the mid-1990s, this effort extended to carriers generally. HCFA announced that it would split the program integrity and claims processing functions and contract for them separately. This split would make it easier for HCFA to use potentially innovative, non-traditional organizations in the program integrity role.

  These HCFA efforts did not cause carrier/intermediary operations to change overnight. Indeed, as detailed in Appendix 3, some contractors have changed radically, while others have not. The point is that these independent efforts moved in a similar direction to ORT, just as ORT was getting under way. Moreover, from the point of view of a Medicare contractor — even a Medicare contractor actively involved in ORT (see Appendix 3) — the sea change in the past few years has been HCFA's change in carrier contracting and operations, not ORT.

- The Department of Justice's expansion of health care anti-fraud efforts — In late 1993 Attorney General Janet Reno declared that health care fraud was the number two priority of the Department of Justice, behind violent crime. One year later, DHHS was completing its planning to implement Operation Restore Trust. Thus, during roughly the same period of time, both DOJ and DHHS began focusing substantially more effort on health care fraud and abuse. That fact alone constitutes a caution to the ORT evaluation:

10 Health Care Financing Administration, "Budget and Performance Requirements 93: Medical Review (Part B)," undated, p. 70.

11 Abt Associates is a subcontractor to the SADMERC, for performing special analyses

in particular, a caution against any offhand causal inferences about what ORT *alone* has brought into being.

- The FBI's expansion of health care anti-fraud efforts — Overall, the FBI has a larger investigative force devoted to health care fraud than OI does (see Appendix 4). However, only in recent years has the FBI taken on such a large role. In 1991, for example, it devoted the equivalent of just 61 agent work-years to health care fraud. That number almost doubled in 1992, and doubled again by 1996. Over the same time period, the number of active health care fraud investigations rose sixfold from 365 to 2,200. The increase reflects the priority attached to health care fraud by the Attorney General, as well as the reality that FBI agents keep finding health care fraud cases to make.

These parallel initiatives suggest that ORT was in some ways only part of a larger wave of activity. Some key interpretive issues — notably, those concerning the sentinel effects of ORT (see Chapter 6) — turn in part on how we view the effects of this confounding.

Chapter 2
OVERVIEW OF THE EVALUATION

ORT operates in a complicated context and is itself a fairly complicated intervention. The evaluation task for this demonstration is notably challenging as a result:[12]

- Ideally, demonstration interventions are isolated in space and time, so that the independent effects of the intervention can be discretely identified. Unfortunately, while ORT is nominally confined to five states and three types of service, nearly everything an evaluator would like to see segregated is somehow confounded. Most of all, there are multiple, simultaneous interventions within ORT itself, even as ORT is coincident with other HCFA, OIG, and DOJ initiatives devoted to roughly the same purpose and involving many of the same people and outside organizations.

- There is no baseline information for many of the key characteristics of interest (e.g., how the ORT regional offices did business before ORT), so it is difficult to establish precise benchmarks against which to identify or measure ORT effects.

- Not all of the ORT effects — indeed, for some purposes (such as measuring actual recoveries to the Trust Fund) *only a small fraction of the likely effects* — have actually occurred. We have employed careful and relatively sophisticated measures to construct the best possible estimates using available information. But it goes without saying that better estimates would be possible after more of the effects had actually occurred.

There are compelling reasons that the ORT evaluation could not be delayed to a moment that was more convenient in technical terms. Most important, the pace of events in the policy world has accelerated. For example, there have been authoritative recent commitments to large new public investments to combat fraud and abuse in health care, including the passage of the Health Insurance Portability and Accountability Act (the so-called Kassebaum-Kennedy legislation) in 1996, passage of the Balanced Budget Act of 1997, the decision by the Secretary of DHHS to expand ORT to 12 additional states, and the commitment of DOJ funds to expand staffing for anti-fraud task forces in U.S. Attorney's Offices nationwide. These commitments of resources mean that good information is essential for informing the key decisions. ORT is one of the most important available laboratories to inform those decisions. Accordingly, our evaluation is designed to provide good information where the best is not available, in order to help inform a set of diverse audiences at a key moment.

This report is the final report of our evaluation. As such, it represents the completion of multiple streams of analytic effort. It includes 11 individual appendixes, presenting the data, analyses, and findings from each major component of our evaluation. These appendixes will give the interested reader an opportunity

12 For further detail on these difficulties, see Abt Associates, Evaluation of Operation Restore Trust: Evaluation Design, report submitted by Abt Associates to the Health Care Financing Administration pursuant to HCFA Contract No. 500-92-0014 (March 21, 1996).

to consult our underlying data and analyses in detail. Meanwhile, in this summary volume, we provide a synthesis of our analysis and findings in terms of the major issues of the evaluation.

ORT is a complex set of interventions, and our evaluation must take account of that complexity. The evaluation does so primarily by using multiple approaches and data sources, so that if ORT has some important effects in a particular area, our evaluation is likely to register those effects and to provide at least a rough estimate of their magnitude.

2.1 Objectives of the Evaluation

The evaluation is designed to address a relatively small set of central objectives:

- To estimate the magnitude of ORT savings, as compared to ORT costs.
- To appraise changes in process and other intermediate outcomes, including:
  - the effects of the partnership model
  - the effects of the additional resources that ORT provided
  - the degree to which the process has become more proactive, moving from emphases on retrospective enforcement to emphases on prevention
  - the effects of key ORT sub-initiatives, including special fraud alerts (SFAs), the Voluntary Disclosure Program (VDP), and the OIG hotline.

These principal objectives helped to define the targets for the evaluation. We have attempted to satisfy these objectives using quantitative and qualitative data and applying methods adapted to the problems raised by the demonstration.

2.2 Priorities

In structuring our specific analytic plans for this evaluation, we followed three general priorities:

- To focus more evaluation resources where more ORT resources were being invested, so that our analyses to some degree reflect the priorities of ORT itself.
- To focus more evaluation efforts where large effects were expected or discovered.
- To analyze more intensively those areas where more reliable data were economically available.

Some choices had to be made, and the above priorities help to explain our choices.

2.3 Data Sources

We have a large set of key data sources for this evaluation, reflecting the diversity of approaches needed to capture ORT effects:

1. We performed multiple site visits to the central offices of each of the partner agencies and gathered extensive documentary data from the central office partners.

2. We completed two sets of site visits to each ORT region, as well as one site visit to two non-ORT regional offices (Boston and Philadelphia). In spring 1997, after ORT concluded, we did follow-up telephone interviews with each ORT region, to update our information on regional activities as ORT came to an end.

3. We used extracts from the Audit Information Management System (AIMS) and the Case Information Management System (CIMS) as the basis for detailed analyses of key quantitative parameters of audits and cases in the OIG.

4. We supplemented those administrative datasets with two special surveys: a survey of pre- and post-ORT cases and a separate survey of ORT-type audits. These two surveys were completed in June 1997.

6. We interviewed key officials in health care fraud at the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) in Washington. In addition, in each of the ORT regions, we interviewed an assistant U.S. attorney and an FBI field agent focusing on health care fraud cases and investigations.

7. We completed seven contractor case studies, five by telephone in fall 1996 and two by detailed site visits in spring 1997. In these studies, as in our interviews with DOJ and FBI officials, our purposes were essentially the same: to understand how these key participants in fraud and abuse processes contributed to ORT and to get their perspective on what was happening in the ORT regions.

8. We had planned to interview approximately 150 providers in early 1997. Due to difficulties in arranging interviews with providers — largely due to provider reservations about talking to us, in the current enforcement climate — we terminated that portion of the evaluation after the pilot test. (See Appendix 10 for a detailed discussion of the provider interviews and the reasons they were canceled.)

9. For indirect data on provider thinking and behavior, we completed selective, claims-based "sentinel analyses," to estimate the deterrent effects of ORT enforcement activities. The data for these analyses included certain linked datasets (e.g., linkage of Part B DME claims to beneficiaries' Part A nursing home stays).

2.4 Methods

With such varied datasets as outlined above, our methods obviously vary, from standard case study approaches for much of the qualitative data to formal econometric methods for some of the large secondary datasets. But across all of these different analyses, we have tested the same basic model of ORT effects: a so-called "double difference" model. The simple logic of that model is to estimate demonstration effects by comparing 1) demonstration results to pre-demonstration results in demonstration areas, as adjusted for 2) secular trends estimated by looking at the pre/post changes in selected comparison areas. This is a

standard, quasi-experimental research design.[13] Its strength is that it allows approximate control for the effects of history, maturation, and other variables, in that the pre/post difference for the demonstration (experimental) group, if larger than for the comparison (control) group, cannot be explained by the effects of such variables as would be found affecting both the demonstration and control groups.

This model represents an ideal, in that most of our data will not support double-difference estimates. But even far afield from quantitative estimates —e.g., in our interviews with staff in ORT and non-ORT regions—the logic of double differences describes how we tried to frame the issues. For example, we have asked demonstration regions how processes changed after ORT (e.g., in implementing data matches), and then attempted, where possible, to calibrate those claimed "demonstration differences" by contrasting them with the pre/post appraisals of the non-ORT regions we visited. In this fashion, we have attempted to force even our most subjective qualitative appraisals into a logic of structured comparisons, to obtain more reliable appraisals of effects and to avoid causal inferences about ORT effects when in fact there are no connections—e.g. where something naturally ascribed to ORT in the ORT regions in fact appears to be happening in all regions.

2.5 Limits of the Evaluation

While the evaluation is ambitious, it does not address all evaluation questions with equal intensity. There are four principal limitations.

First, the evaluation develops far more detailed analyses of OI cases and OAS audits than of either 1) the recoupments of HCFA contractors or the other results of HCFA activities, or 2) the work of AoA. We will have much more to say about the outcomes of OIG activities — especially the activities of OI and OAS — than about the outcomes of HCFA activities. There are three reasons. First, as discussed in Chapter 3, most ORT resources went to OIG. HCFA received much less money, and AoA's share of the budget was extremely small. Second, data on these OIG efforts are centralized, automated, and sufficiently systematic to support rigorous analyses. By contrast, data on the efforts of HCFA and its contractors are just beginning to be centralized at the national level in the Fraud Investigation Database (FID), as discussed in Appendix 3. Data on the outcomes of AoA efforts are limited.

Second, the evaluation addresses some ORT objectives more than others. The five principal ORT objectives were detailed in Chapter 1. Of those five objectives, the Abt evaluation focuses on ORT activities designed to:

- Identify, investigate, and penalize those entities that willfully defraud the Government
- Identify problems of noncompliance with existing statutes and regulations.

For these objectives, the full panoply of evaluation methods and data sources were deployed. In addition, we devote extensive efforts to estimating the savings of ORT in comparison to the resources invested — thereby to assess whether it is economical to draw funds from the Medicare Trust Fund (the "reinvestment fund") to fund fraud and abuse activities.

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13 For example, see Designs 10 and 14 in Donald T. Campbell and Julian C. Stanley, Experimental and Quasi-Experimental Designs for Research (Chicago: Rand-McNally, 1963), pp. 47 – 50 and pp. 55 – 57. In some cases in our analyses, we have experimental and control time series (Design 14); in other cases, our data are limited to pre and post observations in experimental and control areas (Design 10).

For one additional ORT objective — identifying systemic problems relating to program effectiveness and efficiency and vulnerabilities to fraud and abuse — we develop descriptive analyses of the efforts themselves. Moreover, insofar as these efforts yield cases and audits, we estimate their effects with some rigor. However, insofar as these efforts yield major policy initiatives, we do not independently estimate their outcomes. The primary reason is not because proactive policy change is unimportant (it is in some ways the most important goal of ORT), but rather because an effort to estimate the effects of these changes would be:

- costly — A serious attempt to estimate these effects would have consumed most of our evaluation resources.

- premature — The evaluation comes to a close too soon after the policy changes, to obtain reliable estimates of effects.

For two final ORT objectives — allowing providers to voluntarily disclose evidence of fraud, and alerting the public and industry to health care fraud schemes — we provide descriptive case studies, without substantial quantitative analyses. These latter two objectives were less important than the other objectives outlined above; and as the demonstration actually worked out, these activities were not critical to ORT effects we otherwise estimated.

Third, the evaluation collects or exploits some types of data more than others. Certain kinds of data were more practical to obtain than others, and that consideration was of critical importance in our evaluation. Thus, the availability of centralized data on audits and (especially) cases made it possible to do a more comprehensive evaluation of those activities than of most others. At the same time, given the importance of qualitative changes in cases and audits, we surveyed OIG agents and auditors, to obtain richer qualitative data on cases and audits than were available from existing datasets.

The principal data missing for evaluating these OIG efforts are data on OAS audits. These data are missing because the likely disallowances from suspended OIG audits (i.e., audits that have yielded referrals for criminal investigation) are not reported in AIMS. Since suspended audits include notably effective audits and constitute a large proportion of all ORT audits, the absence of this information drastically limits the savings estimates that can be constructed for OAS activities under ORT. The confidentiality of the investigative and judicial processes made it impossible for us to collect the audit-level information that AIMS did not report. The needed information will only be available in future years, too late for this evaluation.

In addition, we faced important data limitations in two areas:

- For HCFA and its contractors, as noted, we had hoped that a new Fraud Investigation Database would be available to permit analyses similar to those we planned for the tracking information available from OIG datasets. Unfortunately, FID is not yet sufficient for that task. We meanwhile could not create an adequate substitute dataset on our own. To create such a dataset, we would have had to collect data from 20 contractor operations for the five ORT states and three ORT subject types. That kind of effort was impractical, given variations in contractor record-keeping and systems, the turnover of contractors over time, and our limited resources for resolving these problems.

- Similarly, our evaluation does not explore provider perspectives on the demonstration. Our evaluation more or less assumes that most government enforcement efforts (e.g., audits and cases) are valid efforts and that few innocent providers are harmed. Given that assumption, "more" enforcement efforts are a social benefit and treated as a positive result in our appraisals of ORT effects. However, providers have raised a number of questions about these enforcement efforts, suggesting that: 1) many of the new enforcement efforts are improper; 2) most cases arise from the government's own failure to provide a clear framework of regulations to guide providers; 3) heightened enforcement harms many innocent providers; and 4) steps taken by legitimate providers to deal with fears of being targeted by investigators are a social cost, offsetting benefits claimed for the heightened enforcement. We should emphasize that the evidence we have seen does not support this view. But we should also emphasize that we did not actively explore these issues. There were two reasons. First, an examination of these issues would require us to talk to providers who are under investigation. That would impossibly compromise government enforcement efforts. Second, even if we had the needed information, appraisal of these issues would require resources and expertise beyond the scope of our evaluation (e.g., to reach a conclusion on such issues as: Did intensified surveys satisfy statutory requirements? Due process requirements? Are HCFA regulations improperly vague?). The absence of information on providers was therefore a necessary limitation on our work. The findings of our evaluation must be read with that limitation in mind.

The final limitation of our evaluation is that we examine only a few of the many possible opportunity costs of the demonstration. Some of the monetary savings associated with ORT almost surely came at the expense of other types of cases or audits that were not undertaken because staff were devoted to ORT activities. For example, because of OAS's emphasis on ORT-type audits, there were fewer audits of HHS operating divisions, state agencies, health centers, and non-profit agencies. In our cost-benefit analyses, the costs of ORT were limited to actual monetary costs of staff diverted to ORT activities, rather than the opportunity costs of such diversions. We do look within the ORT regions to see if the *volumes* of ORT-type cases and audits were expanded at the expense of non-ORT-type cases and audits (in general, there is evidence that such diversions were of some importance for audits, but not for cases). But while we look at selected evidence of such diversions, we do not attempt to estimate the expected savings that would have resulted from cases and audits that were forgone as a result of these diversions. Such estimates are very difficult to do. The fact that they are difficult to do does not change the possibility that these forgone savings could have been larger than the savings we estimate for ORT.

It should thus be obvious that this evaluation does not answer all interesting or important questions about ORT. It does, however, answer those questions for which answers could practically be framed. For other issues — notably, the activities of HCFA, HCFA contractors, and AoA and (for different reasons) savings from the audits of OAS — we have tried to exploit qualitative data to give informed judgments where precise estimates are not possible.

Chapter 3
THE COSTS OF ORT

The costs of ORT can be specified in a number of different ways, given that alternative judgments are possible about what should be attributed to ORT. We therefore have sought to develop a range of costs. See Appendix 10 for a more detailed discussion.

3.1 The Direct ORT Budget

The direct ORT budget was $7.9 million, the total amount that was formally transferred from the Medicare trust funds to DHHS for this demonstration. Of this total, we can document spending of $7.6 million on ORT activities. The remaining $0.3 million may have been spent on ORT activities (these funds were transferred back from OIG to HCFA to fund ORT contractor efforts). But after multiple inquiries to HCFA and others, we could not document that the expenditure of these funds was ORT-related. So we do not include these funds in the ORT total.

For purposes of comparing ORT costs to ORT savings (see Chapter 9 below), the expense of the evaluation — $0.7 million — should arguably be excluded, since the evaluation was not a cost of the efforts that produced the savings. Accordingly, the minimum cost of ORT for such comparison purposes is $6.9 million, but the true historical "cost of the ORT demonstration" was $7.6 million.

Exhibit 1 shows the distribution of total ORT spending by type of expenditure. Exhibit 2 shows the distribution of spending by region.

The funding was unusual in that was it was not appropriated by Congress. By chance, the fact that the funds were not appropriated proved to be very useful during the government shutdowns in 1995-1996, when appropriated funds for travel and other expenses were either unavailable or very tightly restricted.

The ORT budget was divided among the three agencies at the central office level. The Office of the HCFA Administrator controlled disbursements, even though two-thirds of the ORT budget went to the Office of Inspector General. An unusual situation therefore occurred in which millions of dollars of spending by one agency were effectively controlled by another agency. The control of funds by one agency probably encouraged the participant agencies to move in the same direction—even if there otherwise was disagreement on what that direction should be.

Once the funds had been allocated by agency, they were allocated by region in response to requests from each agency's regional office. There was therefore a dichotomy between the ORT goal of encouraging teamwork at the regional level and the continuation of agency-specific funding streams, with little latitude at the regional level to redirect funds across agencies. An alternative approach—which we would not necessarily recommend—would have been for the three central offices to agree on an allocations by region and then have regional officials agree on which projects the allocations should fund. Such an approach would have empowered the regional ORT teams but would have represented a substantial change in traditional ways of doing business.

Exhibit 1. Costs of Operation Restore Trust:
Spending of the ORT Budget by Type of Spending (Dollars in Thousands)

	FY 1995	FY 1996	FY 1997	Total	Percent
Office of Inspector General					
Travel	$312	$1,153	$451	**$1,916**	25%
Other services	$136	$422	$228	**$785**	10%
Hotline	$156	$579	$138	**$873**	11%
Supplies	$19	$667	$17	**$703**	9%
Rental	$103	$503	$89	**$695**	9%
Equipment	$63	$0	$107	**$171**	2%
Printing	$2	$34	$5	**$41**	1%
OIG subtotal	**$791**	**$3,358**	**$1,035**	**$5,184**	**68%**
Health Care Financing Administration					
Travel	$157	$168	$216	**$541**	7%
Other services	$22	$37	$115	**$173**	2%
Supplies	$25	$14	$17	**$56**	1%
Evaluation	$250	$450	$38	**$738**	10%
Rental	$1	$0	$0	**$1**	0%
Survey & certification	$23	$471	$0	**$494**	6%
Equipment	$12	$26	$154	**$192**	3%
Printing	$0	$6	$24	**$31**	0%
HCFA subtotal	**$490**	**$1,171**	**$564**	**$2,225**	**29%**
Administration on Aging					
Travel	$13	$81	$51	**$145**	2%
Other services	$0	$0	$42	**$42**	1%
Supplies	$0	$0	$2	**$2**	0%
Printing	$0	$0	$1	**$1**	0%
AoA subtotal	**$13**	**$81**	**$97**	**$191**	**3%**
ORT TOTAL					
Travel	$483	$1,402	$718	**$2,603**	34%
Other services	$158	$459	$384	**$1,001**	13%
Hotline	$156	$579	$138	**$873**	11%
Supplies	$45	$681	$36	**$761**	10%
Evaluation	$250	$450	$38	**$738**	10%
Rental	$104	$503	$89	**$696**	9%
Survey & certification	$23	$471	$0	**$494**	6%
Equipment	$75	$26	$262	**$362**	5%
Printing	$2	$40	$31	**$72**	1%
ORT TOTAL	**$1,294**	**$4,610**	**$1,696**	**$7,600**	**100%**

Source: Abt Associates Inc., 1997, based on data from OIG, HCFA and AoA.

Exhibit 2. Costs of Operation Restore Trust:
Spending of the ORT Budget by Region (Dollars in Thousands)

	FY 1995	FY 1996	FY 1997	Total	Percent
Office of Inspector General					
California	$105	$668	$172	**$945**	12%
Florida	$118	$601	$209	**$928**	12%
Illinois	$75	$438	$93	**$606**	8%
New York	$36	$332	$58	**$426**	6%
Texas	$83	$432	$122	**$636**	8%
ORT states subtotal	**$416**	**$2,471**	**$654**	**$3,540**	**47%**
Other states	$15	$51	$20	**$85**	1%
Central office	$360	$836	$362	**$1,558**	21%
OIG subtotal	**$791**	**$3,358**	**$1,035**	**$5,184**	**68%**
Health Care Financing Administration					
California	$5	$113	$29	**$146**	2%
Florida	$55	$55	$106	**$216**	3%
Illinois	$5	$97	$10	**$112**	1%
New York	$5	$95	$5	**$105**	1%
Texas	$5	$235	$11	**$252**	3%
ORT states subtotal	**$75**	**$596**	**$160**	**$831**	**11%**
Other states	$0	$0	$0	**$0**	0%
Central office	$415	$575	$404	**$1,394**	18%
HCFA subtotal	**$490**	**$1,171**	**$564**	**$2,225**	**29%**
Administration on Aging					
California	$2	$25	$22	**$49**	1%
Florida	$2	$11	$17	**$30**	0%
Illinois	$1	$6	$19	**$26**	0%
New York	$1	$11	$24	**$36**	0%
Texas	$4	$17	$3	**$24**	0%
ORT states subtotal	**$10**	**$70**	**$86**	**$166**	**2%**
Other states	$0	$0	$0	**$0**	0%
Central office	$2	$11	$11	**$25**	0%
AoA subtotal	**$13**	**$81**	**$97**	**$191**	**3%**
ORT TOTAL					
California	$112	$806	$223	**$1,140**	15%
Florida	$175	$667	$331	**$1,174**	15%
Illinois	$81	$541	$122	**$745**	10%
New York	$42	$438	$86	**$567**	7%
Texas	$92	$684	$136	**$912**	12%
ORT states subtotal	**$501**	**$3,137**	**$899**	**$4,537**	**60%**
Other states	$15	$51	$20	**$85**	1%
Central office	$778	$1,422	$777	**$2,977**	39%
ORT TOTAL	**$1,294**	**$4,610**	**$1,696**	**$7,600**	**100%**

Notes

1) 1995 division by region for OIG is an estimate, using the same percentage splits for OAS and OI as were true in 1996.

2) 1995 division by region for HCFA is an estimate. It reflects the actual number for central office, an approximation for Florida, and the equal division of the remaining $19,989 among the other four states.

3) Central office spending is a modest over-estimate, since central office paid for some regional expenses.

Source: Abt Associates Inc., 1997, based on data from OIG, HCFA and AoA.

A number of points should be noted about how the ORT budget was spent:[14]

- No funds were spent on salaries and other personnel expenses — The ORT budget covered only non-personnel costs such as travel, rental, equipment and supplies. Very minor amounts of funds were used for personal services contracts.

- Two-thirds of the budget was spent by OIG — OIG spent $5.2 million (68% of the total) while HCFA spent $1.5 million (20%) and the Administration on Aging $0.2 million (3%). The balance of the budget ($0.7 million, or 10% of the total) was devoted to the evaluation, which was directed by HCFA.

- Medicare contractors received only incidental funds — Medicare contractors were one of the most notable exclusions from the inside group of funded partner agencies. Although the contractors were involved in some Operation Restore Trust projects, the funding they received was occasional and small.

- ORT funding began slowly — On paper, the demonstration started April 1, 1995. But the formal announcement by President Clinton did not occur until May 3, 1995, and the regions did not receive their first actual disbursements from the ORT budget until August 1995. The period from April 1995 to September 1995 accounted for 25% of the demonstration period but only 17% of ORT spending.

- Travel was the single largest expense — Travel costs for federal employees were $2.6 million. Another $0.5 million was paid to state survey and certification agencies, and most of that amount covered travel by state employees on ORT work. Thus, an amount approaching $3.1 million of the direct ORT budget (or 41% of the budget) went for travel. Again and again we heard from regional officials how important the travel money was to ORT projects.

- The hotline and this evaluation were the next most expensive items — The expanded OIG hotline was the next most expensive single cost, accounting for $0.6 million in payments to the hotline contractor (Raymond Maria Group Ltd.) and at least another $0.3 million for telephone and related costs. Meanwhile, the cost of the Abt evaluation was $0.7 million. Both of these items appear under central office spending in Exhibit 2.

- Florida and California received the most funding — $4.5 million was spent by the ORT regions. Among the regions, Florida had the largest budget ($1.2 million), followed by California ($1.1 million), Texas ($0.9 million), Illinois ($0.7 million), and New York ($0.6 million).

One important point to note in reviewing the direct ORT budget is that, notwithstanding that the budget was relatively small, it provided critical amounts of discretionary funds, at a historical moment when funds for such key items as travel were being reduced. But if such discretionary funds were important, they only begin to summarize the costs of the ORT effort. Other arguable costs of ORT are summarized below.

14 Note that, in some of the descriptions below, the numbers do not sum to $7.6 million, due to rounding.

3.2 Indirect Cost Components

Different sets of indirect costs — costs outside the "ORT budget" — can be attributed to ORT, as detailed below.

3.2.1 Additional OIG Staff

Although the direct ORT budget did not include personnel costs, there was an increase in OIG staff directly attributable to the demonstration. In the spring and summer of 1995, OIG hired 29 additional staff who worked almost exclusively on ORT projects. Of the 29, 24 were OI agents, 2 were OAS staff, and 3 were OEI staff. We estimate the total cost of these additional resources at about $3.0 million over the two years of the demonstration.

While they were not funded by the ORT budget as such, these additional staff were hired for and almost exclusively devoted to ORT projects. As a result, the cost of these staff is "indirect" in only the most formal terms. The cost of these staff should be considered an ORT expense under any reasonable definition of ORT expenses.

To get some idea of the significance of these additions, note that OI staff in the ORT states totaled 79 at the time ORT began, of whom 56 were investigators. The addition of 24 investigators therefore represented *an increase of 43% in investigative staff in the ORT states*. To be sure, the less experienced of the new hires could not have been immediately productive, but this is a major staff infusion in the ORT regions by any measure. These additional staff were important to the demonstration. It is worth noting, however, that at the same time as OIG staffing in the ORT states was increasing, it was falling in other states, so nationwide OIG staffing was essentially unchanged as of October 1996 (925 in October 1996 compared with 923 in April 1995). Total OIG staffing rose to 1,063 by the end of the demonstration (March 1997), but the increase was not part of Operation Restore Trust.[15]

3.2.2 Efforts of Existing DHHS Field/Regional Staffs

ORT made significant use of pre-existing DHHS staff in the field — staff who would have been in place, with or without ORT. For OAS alone, a total of 21,686 days were recorded on ORT-related audits. The imputed cost of these staff (net of the two staff funded under the direct ORT budget) was on the order of $4.8 - $5.5 million (see Appendix 10), a figure reflecting the approximate cost of the time contributed to ORT projects by OAS auditors in ORT and non-ORT states.[16] We have no data on the similar efforts of

15 Thirty-nine personnel were transferred from the DHHS Office of the General Counsel to form a new Office of Counsel to the Inspector General. Most of the remaining increase reflected increases in staffing following the enactment of the Health Insurance Portability and Accountability Act of 1996.

16 These figures assume that one FTE costs $60,000, or the approximate average cost of the staff added to OIG under ORT, as described in the preceding section. Note that the ORT-connectedness of the non-ORT state staff time (worth $0.7 million) is not as clear cut as the ORT state staff time, so that the $5.5 million estimate should be viewed as an upper bound on additional OAS staff costs.

OI, OEI, HCFA, and AoA. We arbitrarily assume the imputed costs of these other agencies to be another $3.5 million.[17]

Thus, under the most generous assumptions, there were roughly $ 9.0 million in imputed staff costs for ORT projects. The important evaluation issue is whether these amounts are "ORT costs." In the sense of being costs that would have been incurred anyway, they arguably are not part of the "marginal cost of ORT," to be compared to marginal benefits of the demonstration. However, these efforts were devoted to ORT projects; strictly speaking, their "cost" is not the labor cost outlined above, but rather the opportunity cost of diverting these personnel to ORT work. That is, if we could calculate the opportunity costs (which represent what was given up to focus on ORT), we would ignore the labor costs of the personnel (which would have been incurred anyway).

The estimation of opportunity costs is notoriously difficult, however, and we will not attempt to do so here. Instead, we will take a fairly practical approach to these costs. First, we will use labor costs as our best estimate of the opportunity costs of these efforts. Second, we will offer a range of indirect cost estimates, rather than a single point estimate for these costs.

3.2.3 Efforts of Personnel Outside DHHS

Many outcomes we have identified as "ORT outcomes" are attributable at least in part to activities of people outside DHHS: contractors, U.S. Attorney's Offices, state agencies on aging, state survey and certification agencies, Medicaid agencies, the FBI, and other law enforcement agencies. For each of these non-ORT agencies, ORT activities were undertaken as part of the organization's conventional, non-ORT responsibilities (e.g., ORT recoupments by Medicare contractors were part of standing contractual obligations for contractors to perform recoupments — the recoupments just happened to be ORT-related when contractors worked with ORT teams). However, in most of these cases, non-ORT agencies made special efforts for ORT projects, given the priority attached to ORT projects by the partner agencies.

We have no data to quantify these efforts. Even if we had such data, it would be difficult to include such costs as ORT costs, since (for these more remote organizations) we would face a more difficult version of the issues raised in the preceding section. Accordingly, we do not include any allocation of costs for the efforts of these organizations.

3.2.4 Efforts of Senior DHHS Managers

Senior managers in HCFA, OIG, AoA and the Office of the Secretary of DHHS have spent unusual amounts of time on the ORT demonstration. We ignore these costs in our cost estimates. However, we would like to emphasize that the attention and commitments of senior management were a key to the results of the ORT demonstration, in that they focused the attention and mobilized the efforts of regional

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17 The basis of the $3.5 million is crude: $1 million each for HCFA, OI, and OEI; and $0.5 million for AoA. To get some sense of an upper bound on these costs, consider the OI component. In April 1995 when ORT began, OI had 79 FTEs in ORT states and 138 FTEs in non-ORT states. Assume that each FTE costs $60,000 per year. If all of the 79 ORT-state agents spent one-quarter of their time on ORT for the two years of the demonstration, the total cost would be $2.4 million. If all of the agents in non-ORT states spent 10% of their time on ORT for the two years of the demonstration, the total imputed cost to the demonstration would be $1.7 million. Thus, if ORT took over the work of OI to this extreme, the imputed cost would be $4.0 million (rounded) for the two years of the demonstration. It is important to note that we have no evidence that ORT took over the work of OI nationwide to this extreme, indeed, the evidence from CIMS on the volume of cases suggests that there was relatively little diversion of effort in OI

and field offices, Medicare contractors, and a whole array of non-ORT organizations. Indeed, senior management attention and the priority assigned to ORT may be the most important special condition of the ORT demonstration and the scarcest resource of all, in the sense of being extremely difficult to sustain indefinitely. As ORT-style efforts continue in the ORT states and expand to new states, the importance of this scarcity may become more visible.

3.3 ORT Costs: Summary of the Range

Exhibit 3 summarizes our different cost estimates. Our estimates of ORT costs range from $6.9 million to $18.9 million:

- $6.9 million is the minimum cost of ORT, in terms of ORT expenses (excluding the evaluation) explicitly funded by the ORT budget (i.e., by the transfer from the Medicare Trust Fund).

- $9.9 million is the total direct cost of ORT. It includes all costs in the minimum estimate, plus $3.0 million in ORT-dedicated staff funded out of non-ORT budgets.

- $15.4 million is the total of ORT expenses we can document. This estimate includes all direct costs, plus an upper bound of $5.5 million in staff costs in an area (OAS audits) for which we have evidence of diverted staff effort.

- $18.9 million is our highest cost estimate. It includes all documented costs, plus an estimate of $3.5 million for staff costs that, in the absence of clear documentation of the relationship to ORT, we have estimated.

There is a temptation to subdivide this total cost estimate into discrete amounts more or less directly attributable to particular agencies. (For example, we could extract OI costs from this total, to compare to our estimate of ORT's effect on cases OI develops.) The principal problem with doing this adjustment is that it ignores joint products across agencies. (To continue the OI case example, it ignores that these cases are a resultant of many efforts, not just OI efforts.) One of the key premises of ORT was precisely that such joint or collaborative products are important and undervalued. We therefore will refrain from making agency-specific attributions of cost, for purposes of any cost-benefit comparisons. However, for reference purposes, Exhibit 4 below shows how the $18.9 million should be apportioned to individual agencies.

Exhibit 3. ORT Demonstration:
Alternative Cost Estimates (Dollars in Millions)

Estimate	Description	Amount	What is included
1	The formal definition of "ORT costs," excluding costs of the evaluation	$ 6.9	Expenses funded out of the ORT budget (i.e., out of the transfer from the Medicare Trust Fund), excluding $0.7 million in evaluation costs and $0.3 million not clearly spent on ORT.
2	Total direct costs clearly devoted to ORT, that would not have been incurred in the absence of ORT	$ 9.9	Estimate 1, plus $3.0 million for personnel added to support ORT.
3	Direct costs plus documented indirect costs	$15.4	Estimate 2, plus an upper bound of $5.5 million in OAS staff costs on ORT projects.
4	Direct costs plus documented and undocumented indirect costs	$ 18.9	Estimate 3, plus a $3.5 million estimate for the time of OI, OEI, HCFA, and AoA staff devoted to ORT.

SOURCE: Abt Associates Evaluation of Operation Restore Trust, 1997 (Appendix 10).

Exhibit 4. ORT Demonstration:
Costs (per Estimate 4) by Agency (Dollars in Millions)

	OIG							
Cost Element	**OI**	**OAS**	**OEI**	**Other**	**Total**	**HCFA**	**AoA**	**All ORT Partners**
Direct ORT Budget	$2.0	$1.5	$0.5	$1.2	$5.2	$1.5	$0.2	$6.9
Added staff	$2.5	$0.2	$0.3	$0.0	$3.0	$0.0	$0.0	$3.0
Documented indirect staff	$0.0	$5.5	$0.0	$0.0	$5.5	$0.0	$0.0	$5.5
Undocumented indirect staff	$1.0	$0.0	$1.0	$0.0	$2.0	$1.0	$0.5	$3.5
TOTAL	$5.5	$7.2	$1.8	$1.2	$15.7	$2.5	$0.7	$18.9

Note: Costs of the evaluation are excluded from the total. "Other" expenses for OIG include central office expenses not attributable to OI, OAS, or OEI. Totals for rows or columns may not equal sum of component items, due to rounding.

Source: Abt Associates Evaluation of Operation Restore Trust, 1997 (Appendix 10).

Chapter 4
FINDINGS OF THE EVALUATION 1: THE EFFECTS OF ORT ON OI CASES

The cases developed by the Office of Investigations are not the only outcome of interest in ORT. However, the view of ORT through cases is synoptic: efforts ORT sought to orchestrate — in such areas as more data-driven case identification, more collaboration among the partner agencies, and others — had a *large part of their effects* in the ultimate development of cases by OI. Accordingly, a key hypothesis of the evaluation is that ORT will increase the volume of OI cases and will change the character of those cases in ways reflecting the new collaborative thrust of the demonstration. That is indeed what we found.

The data for our analysis of OI cases come from three sources: interviews with investigators in the central office and in the field (Appendix 1); a quantitative analysis of data in the Case Information Management System (CIMS), the primary tracking system for OI cases (Appendix 5); and a survey of cases, which represents investigators' abstracts of key characteristics of sampled pre- and post-ORT cases (Appendix 7).

Before presenting the results of our analyses, it will be useful to note here one important practice that we follow in our analyses. Specifically, we do not to treat all CIMS-identified cases (i.e., all matters with a separate case number) as homogeneous. "Exclusion" cases are generally presented separately. The reason is that these cases usually represent administrative follow-up work to enforcement actions by others outside DHHS/ OIG (e.g., follow-up work to exclude providers from Medicare, after states assess Medicaid liability against providers)[18]. Such follow-up work is minimally affected by ORT in the best of circumstances, as there is no independent identification of subjects and the cases frequently open and close on the same day. Accordingly, we focus our analyses on non-exclusion cases and briefly present separate results for exclusion cases.

One other particularly important point should be emphasized. Our evaluation more or less assumes that most cases are valid cases and that few innocent providers are harmed. (See discussion in Chapter 2.) Given that assumption, "more" cases are a benefit. That is a reasonable working assumption, but it is subject to considerable dispute from some provider groups.[19]

Granting these limitations, we have found substantial effects that make a strong case that ORT accomplished its objectives. We begin by reviewing the amount and character of this activity under ORT.

18 More generally, an "exclusion" is an administrative action by which a provider/supplier is barred from receiving Medicare reimbursement for a defined period of time. OI processes exclusion cases, but the work is largely administrative.

19 E.g., see "Beware the New Health Care Police — An Editorial." The Insider [newsletter of the American Federation of Home Health Agencies], September 17, 1996; as reported on the AFHHA's home page.

4.1 OI Cases: Volume and Character[20]

1. ORT is associated with a substantial increase in the volume of cases against ORT subject-type providers.

Non-Exclusion cases[21]. ORT had a large net impact on the volume of non-exclusion cases opened by OI. Across the five demonstration states, volume increased by 62%, from 164 to 265 cases during ORT (Exhibit 5). Given the 20% decline in ORT-type cases that opened in comparison states during the ORT period, our best estimate is that *ORT was associated with a 103% net increase in the number of non-exclusion cases opened against ORT focus area providers.*

The impact of ORT on volume was consistent throughout the two-year demonstration period (see Appendix 5, Exhibit 5-6). During every quarter of ORT, the number of cases opened in ORT states was higher than the highest number of cases (25) that opened during any pre-ORT quarter. Even in the first quarter of ORT, before many ORT projects had begun, volume increased to 27 cases, from an average of less than 20 cases per quarter in the year preceding ORT. *It would thus appear that high-level attention and mobilization of staff alone had some impact on case volume, since, in the early period, none of the ORT resources had been released.*

Exclusion cases. While the number of exclusion cases increased from 72 to 184 in ORT states during ORT (a 156% increase), we estimate that ORT was actually associated with an 8% net decrease in the volume of exclusion cases, since volumes increased even more in comparison states (Exhibit 6).

2. The increase in volume of cases has been especially notable in Texas and New York.

ORT was associated with a higher volume of both exclusion and non-exclusion cases in all five demonstration states. For non-exclusion cases, the largest increases in volume occurred in New York and Texas (Exhibit 7). With respect to exclusion cases, Texas and Florida had the largest increases in volume (data not shown), though, as noted above, the volume of exclusion cases increased more in comparison states. By state, the notable results for non-exclusion cases were as follows:

- California — In California, the number of non-exclusion cases increased by 24%, from 46 to 57 cases. Most of the increase was due to higher volume of HHA cases.

- Florida — Florida had a smaller percentage increase in non-exclusion cases than any other ORT state. Volume increased from 30 to 34 cases, a 13% increase. This increase was spread across all three major ORT focus areas.[22]

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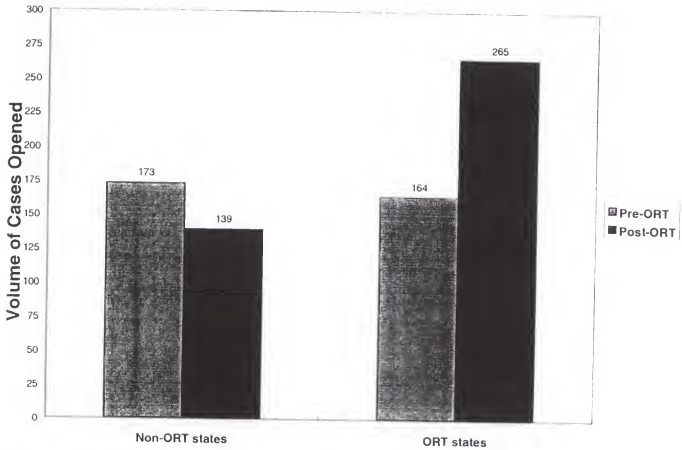
20 In our discussion of cases in this chapter and audits in the next chapter, all information on volumes refers to unadjusted volumes, except when we refer to "net" effects. "Net" changes in ORT states in each case represent adjustment of nominal volume differences to take account of the trend of changes in non-ORT states (i.e., "double differenced" estimates of ORT effects).

21 Non-exclusion cases are those that did not result in an exclusion.

22 During our site visit discussions, we learned that OI in Florida was reluctant to accept HHA cases (the St. John's case is a notable exception), a reluctance that OI attributes to difficulties in getting the U.S. Attorney's Office in Miami to prosecute such cases. This fragment of information makes the perhaps obvious point: case development is a process influenced by "demand" of U.S. Attorney's Offices, as well as the "supply" of potential cases developed by the OI field office.

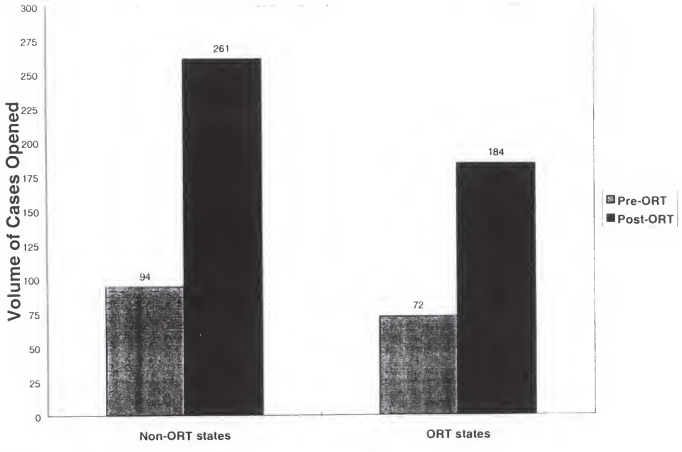
Exhibit 5: ORT Impact Analyses
Volume of Cases Opened Non-exclusion Cases Only



Source: CIMS (Figures as of May 28, 1997)

Notes:
1. Includes ORT subject types only (DME supplier, Home Health Agency, Nursing Home and Hospice)
2. Non-ORT states include all non-ORT states with an OI suboffice.
3. Pre-ORT period includes cases opened 4/93-3/95. Post-ORT period includes cases opened 4/95-3/97.

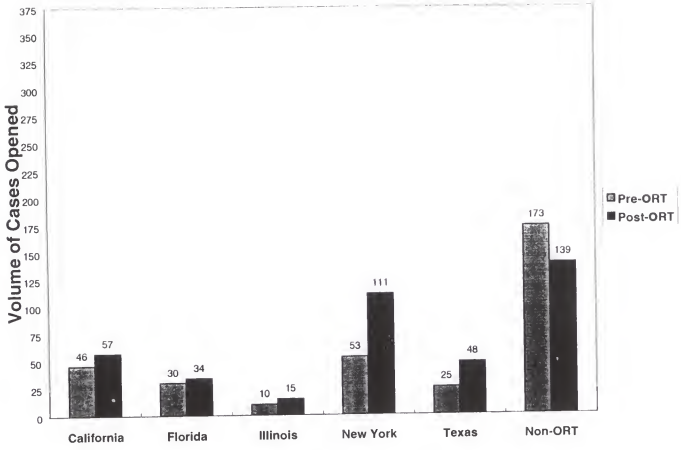
Exhibit 6: ORT Impact Analyses:
Volume of Cases Opened - Exclusion Cases Only



Source: CIMS (Figures as of May 28, 1997)

Notes:
1. Includes ORT subject types only (DME supplier, Home Health Agency, Nursing Home and Hospice).
2. Non-ORT states include all non-ORT states with an OI suboffice.
3. Pre-ORT period includes cases opened 4/93-3/95. Post-ORT period includes cases opened 4/95-3/97.

Exhibit 7 ORT Impact Analyses
Volume of Cases Opened by State - Non-exclusion Cases Only



Source: CIMS (Figures as of May 28, 1997)

Notes:
1. Includes ORT subject types only (DME supplier, Home Health Agency, Nursing Home and Hospice).
2. Non-ORT states include all non-ORT states with an OI suboffice.
3. Pre-ORT period includes cases opened 4/93-3/95. Post-ORT period includes cases opened 4/95-3/97.

- Illinois — During both the pre- and post-ORT periods, Illinois had the smallest number of non-exclusion cases. The volume of non-exclusion cases increased from 10 to 15 during ORT. All of the increase was attributable to an increase in cases against DME suppliers (there was a decrease in the number of HHA cases, and only 2 SNF cases opened during ORT).

- New York — The volume of non-exclusion cases in New York more than doubled during ORT, with large increases in the volume of cases for all three major ORT focus areas. Before ORT, virtually all of New York's ORT-type cases were DME cases, and ORT brought a substantial increase in DME cases. But OI investigators in New York also broadened their focus beyond DME, to include major increases in HHA and SNF cases.

- Texas — In Texas, the number of non-exclusion cases nearly doubled.[23] This increase was the result of a dramatic increase in HHA cases, which increased by nearly 200% during ORT. The number of DME supplier cases did not change during ORT, and there were only three non-exclusion SNF cases in Texas during the demonstration period.

3. *Under ORT, case subject types have changed*

ORT was associated with a large increase in volume across all three major ORT focus areas (Exhibit 8). If we adjust the nominal increases in Exhibit 8 to take account of the pattern observed in comparison states, ORT was associated with the following net (i.e., double-difference) effects for non-exclusion cases:

- a 167% increase in home health agency cases.

- a 146% increase in cases opened against DME suppliers.

- a 46% increase in nursing home cases.

4. *The major increases in case volume described above were obtained without apparent diversion of OI field staff from non-ORT states.*

It was a reasonable hypothesis that increases in case volume under ORT would come at the expense of other case-development efforts. Our evidence on issues of such "opportunity costs" is fragmentary at best. However, we were able to examine the volume of *ORT-related* cases in comparison states, to see if there was visible diversion of effort on such cases from non-ORT states to ORT states within ORT regions. We found no such evidence: i.e., for comparison states, changes in volume of such cases were comparable for ORT and non-ORT regions (see Appendix 5). Had the volume changed disproportionately in the ORT regions, that result might have suggested that such cases were dropped in non-ORT states to pursue cases in ORT states.

23 It is also worth noting that the number of exclusion cases in Texas increased by more than 300% during ORT, the largest increase in exclusion cases in any ORT state.

Exhibit 8
ORT Impact Analyses:
Non-Exclusion Cases Opened by Subject Type

Subject Type	ORT states			Comparison states		
	Pre-ORT period	ORT period	% Change	Pre-ORT period	ORT period	% Change
DME supplier	123	163	+32%	114	62	-46%
Home health agency	29	72	+148%	43	40	-7%
Hospice	1	1	0%	0	4	--
SNF	11	29	+164%	16	34	+113%

Source: CIMS, 1997.

5. ORT has been associated with a change in the mix of case referral sources, in a direction consistent with the objectives of ORT.

If the partnership model was implemented effectively, then the referral sources for OI cases should diversify. That is in fact what we found (Exhibit 9) . We found increases in referrals by beneficiary/employees/anonymous, OAS, HCFA/HCFA contractors, and (especially) state agencies in our CIMS data. In our survey of cases, we had a similar result: referrals from MFCUs were of particular importance (see Appendix 7). It is interesting to note that much of the increase in referrals from state agencies was due to higher volume in New York. The significance of that result is simple: New York was the one state where the state government most actively collaborated in ORT efforts. It appears that kind of commitment made a big difference in the results.

6. ORT was associated with an estimated 20% increase in the number of cases accepted for prosecution.

As shown on Exhibit 10, there was a 20% net increase in the number of cases accepted for prosecution. (This is a double-difference estimate based on a slight increase in the ORT states, from 41 to 43; and a decrease in the non-ORT states, from 32 to 27.) As more ORT state/ORT period cases mature, the relative increase will grow, since the ORT states and the ORT period have a larger proportion of pending cases than the comparison states and the pre-ORT period.

Exhibit 9. ORT Impact Analyses:
Number of Non-Exclusion Cases Opened, by Referral Source

	ORT states			Comparison states		
Referral Source	**Pre-ORT period**	**ORT period**	**% Change**	**Pre-ORT period**	**ORT period**	**% Change**
Beneficiary/employee/anonymous	21	44	+110%	32	24	-33%
HCFA	5	8	+60%	6	2	-67%
HCFA Contractor	53	81	+53%	38	35	-8%
HHS (principally OAS)	17	25	+47%	27	26	-4%
Hotline	2	13	+550%	2	3	+50%
Local police/local prosecutor	2	0	-100%	2	1	-50%
State Agency	28	70	+150%	24	16	-33%
Qui-Tam	9	5	-44%	11	13	+18%
Dept of Justice	11	5	-54%	15	7	-53%
U.S. Attorney's Office	5	7	+40%	15	8	-47%
AOA/SSA/Public Health Service	2	2	0	0	1	--
Other	8	5	-38%	1	3	+200%
TOTAL	164	265	+62%	173	139	-20%

Notes: Hotline calls include: a) all cases with a Hotline identification number recorded in CIMS, or b) a source code of "Federal government hotline" or "Federal HHS Hotline". State agencies include Medicaid Fraud Control Units (Sub-source code 700) and "State/local public asst" (Sub-source code 710). HHS source codes include the following sub-source fields: HHS/Office of General Counsel, Dept. of HHS, Audit, and Dept of HHS/OIG and the "Audit" major source field.

Source: CIMS, 1997.

Exhibit 10. ORT Impact Analyses:
Impact of ORT on Case Development (Non-Exclusion Cases)

Date case opened: (observation period)[1]	ORT states		Comparison states	
	4/93-3/95 (pre-ORT period)	4/95-3/97 (ORT period)	4/93-3/95 (pre-ORT period)	4/95-3/97 (ORT period)
Cases opened	164	265	173	139
Cases closed	55	83	63	69
Cases opened but pending	109	182	107	70
% of open cases that were pending at end of period	67%	69%	62%	50%
Total trial/pre-trial diversions	6	23	13	14
Criminal	1	5	5	2
Civil	5	18	8	12
Total cases accepted for prosecution	41	43	32	27
Criminal	27	26	18	13
Civil	14	17	14	14
Total criminal indictments	1	7	2	1

Note: 1. Figures reported in this table are as of observed at the end of the appropriate observation period. The end of the observation period is defined as 5/28/95 for the pre-ORT period and 5/28/97 for the ORT period. (See Appendix 5 for more detail).

2. Case development dates are based on date of criminal trial/pre-trial settlement for criminal and civil cases. If this date is not recorded, then outcome is based on the date that the case closed.

Source: CIMS, 1997

4.2 Qualitative Changes in Case Outcomes

1. There is some evidence to suggest that the ORT cases are, on average, of higher quality than pre-ORT or comparison cases.

Our evidence on case quality comes from two sources. First, our analysis of CIMS shows that a larger number of cases went to trial under ORT than in pre-ORT periods and comparison states (see Exhibit 10). In the ORT states, 6 cases went to trial or had a pretrial diversion (i.e., a settlement) before ORT. After ORT, 23 cases went to trial or settled over a comparable period. In comparison states, the number of cases that went to trial or settled was little changed. The large relative increase in cases going to trial or having a pre-trial settlement in the ORT states/ORT period could, of course, be due to selective increases in "demand" — i.e., to the more active efforts by U.S. Attorneys *in the ORT states, but not the comparison states* to develop cases quickly. But it could also be due to selective increases in "supply" — i.e., to OI's providing higher quality cases to prosecutors in ORT states but not the comparison states at an earlier stage in the case timeline. There are some discrete procedural reasons why the latter might be true, such as the greater use of task forces and inter-agency collaboration to shape investigations at an earlier stage.

A second source of evidence on the question of case quality is from our survey of cases, which compares unadjusted case characteristics and outcomes of pre- and post-ORT cases. This area was problematic to survey, since (compared to pre-ORT cases) post-ORT cases: 1) had a shorter period of time to yield positive outcomes, and 2) were disproportionately excluded from our survey due to grand jury secrecy and other concerns. What is notable in our results is that, notwithstanding these problems, post-ORT non-exclusion cases already show a higher rate of positive outcomes than pre-ORT cases. We can define "positive outcomes" to include:

- A referral to the U.S. Attorney, the FBI, or other law enforcement agency,
- Filing of formal civil or criminal charges,
- Exclusion,
- Recoupment, or
- Other (e.g., provider bankruptcy).

Exhibit 11 suggests that there has been a noticeable increase in cases with a positive outcome: from 53% of all cases (pre-ORT) to 73% of all cases (post-ORT).[24] Already, it appears, the ORT cases show signs of higher quality than their pre-ORT predecessors — notwithstanding that we would expect the post-ORT figure to be biased downward, compared to figures for pre-ORT cases.

24 Cases that span the pre- and post-ORT periods have a somewhat higher figure for positive outcomes (81%), which could reflect their longer gestation period as of the time of the survey, or the influences of ORT, or both.

Exhibit 11. Survey of Cases:
Significant Case Outcomes for Non-Exclusion Cases

Response	Pre	Bridge	Post
Total with a positive outcome [1]	53%	81%	73%
Total without a positive outcome [2]	47%	19%	27%
TOTAL	100% N = 19	100% N = 31	100% N = 37

Note: 1) Positive outcomes include: referral of some kind, formal criminal or civil charges, exclusion and recoupment.
2) Reasons for cases without a positive outcome include: case closed, no outcome, no answer, don't know.

Percentages may not sum 100% due to rounding.

Source: Abt Associates, 1997

5. *There are signs that the follow-up to post-ORT cases is more pro-active than for pre-ORT cases.*

Another area where ORT sought to improve on traditional practices was in what might be termed "case follow-up." In the past, enforcement processes often failed to take a given case and follow-up on its implications in a proactive way. Our evidence on this score (from our survey of cases) is fairly striking. As shown on Exhibit 12, there were large increases in the proportion of cases with the following kinds of follow-up:[25]

- Exploration for providers exhibiting the same pattern — Cases with exploration for other instances of similar abuses more than tripled, from 11% pre-ORT to 38% post-ORT.
- Subsequent *written* policy recommendations — Cases that led to explicit policy recommendations increased from 5% to 11%.
- Meeting with someone outside OIG concerning the case — The proportion of cases on which investigators met with someone outside the agency to follow-up on the case more than doubled, from 11% of the pre-ORT cases to 27% of post-ORT cases.
- Meeting with a Medicare contractor or submission of a written recommendation to change some aspect of contractor operations — Follow-up work with Medicare contractors increased slightly, from 5% to 8%.
- Issuance of a Management Implication Report (MIR) — MIRs were issued in 5% of the pre-ORT cases, but 19% of the post-ORT cases.
- No follow-up — Cases with no follow-up action declined substantially, from 68% pre-ORT to 41% post-ORT.

These results are consistent and surprisingly large for almost all measures.[26]

25 Note that these follow-up categories are not mutually exclusive, so the percentages do not add to 100%.

26 Other data from the survey offer some insight into the timing of the follow-up that occurred. In 34% of the post-ORT cases — but only 26% of the pre-ORT cases — follow-up occurred at what might be termed an "early" moment: i.e., before the case closed and/or before the case was referred. See Appendix 7.

Exhibit 12. Survey of Cases :
Follow-up Actions on Cases, by Type of Case

	Non-Exclusion			Exclusion		
Follow-up Action	**Pre**	**Bridge**	**Post**	**Pre**	**Bridge**	**Post**
Commenced investigations of similar providers	11%	10%	38%	8%	0%	4%
Submitted written recommendations for policy changes	5%	0%	11%	0%	0%	4%
Met with agency outside OIG	11%	16%	27%	0%	0%	0%
Met with or submitted recommendations to Medicare contractor	5%	13%	8%	0%	0%	0%
Issued a Management Implication Report	5%	16%	19%	0%	0%	4%
Other	0%	7%	3%	0%	0%	0%
No Follow-up Actions Taken	68%	52%	41%	85%	100%	93%
No Answer	0%	3%	3%	8%	0%	0%
Total	**n/a N = 19**	**n/a N = 31**	**n/a N = 37**	**n/a N = 13**	**n/a N = 1**	**n/a N = 27**

Note: Respondents were encouraged to cite all follow-up actions taken as a result of the case, so rows are not mutually exclusive and percentages sum to more than 100%. The "Bridge" period refers to cases that opened in the pre-ORT period but were still pending when ORT started.

Source: Abt Associates, 1997

4.3 Preliminary Estimates of "ORT Savings" from OI Cases

4.3.1 The Challenge of Estimating ORT Savings

One of the most critical issues for appraising the ORT demonstration is whether or not the initiative produced significant savings. In turn, one key component of those potential savings — though by no means the total savings — is the savings from OI cases. Ideally, we would measure "savings" from such cases as the incremental dollar returns attributable to ORT. But we cannot exactly measure the incremental dollar returns attributable to ORT. There are two major problems:

- The data on receivables is good, but the data on actual recoveries are limited for the time being — We have good data on *receivables* for cases from pre- and post-ORT periods and from demonstration and comparison states. However, except for one group of cases (post-ORT period/ORT state cases), we do not have good data on actual *recoveries*.[27] And even for the post-ORT/ORT-state cases for which recovery data are available, the results are significantly truncated, as some large fraction of the dollar recoveries likely to occur have not yet occurred. Without historical recovery data on older cases that are completed, or future recovery data on the ORT-period cases that have not yet matured,

27 The fact that we have good data on this one group of cases is itself the result of an unheralded initiative under ORT. With the passage of time, if these data continue to be collected, the difficulties described in the text will be substantially resolved. It will be possible, that is, to develop informed estimates of how receivables (e.g., by type of case) translate into recoveries.

there is no data-driven way to estimate how the incremental receivables we estimate to be caused by ORT will translate into actual dollar recoveries.

- Notwithstanding the good data on receivables, predictions about receivables are still uncertain — Many cases are too young to have generated a receivable or other outcome. Given the large, often unpredictable receivables that result from cases, our estimates of ORT impacts could change dramatically as pending cases mature and reach a final outcome.

Accordingly, we are not in position to prepare a definitive savings estimate as yet. This difficulty is the most significant cost of scheduling the conclusion of the evaluation so close to the end of ORT, before a whole array of case and other outcomes from the ORT period have accrued. Still, it is possible to prepare reasonable estimates within the limitations of available data and uncertainties.

We have developed a range of different savings estimates, taking into account possible alternative views of what should count as an ORT savings. The estimates are based on *two types of cases*: "pure ORT cases" that opened during the demonstration period; and "ORT-influenced" or "bridge" cases that opened in the pre-ORT period but were still pending when ORT started.[28] It is possible to view ORT effects as exclusively the result of cases which opened during ORT. It is also possible to argue that ORT affected cases already pending when ORT started, although the risk of including such cases is that ORT savings will be overstated.

In turn, for each of these two different types of cases, we explore *three different proxies for ultimate ORT "savings,"* proxies that can be estimated from available data. These proxies are listed below in the order of increasingly expansive definitions of savings:

- Medicare recoveries ("money in the bank") — Using HCFA data on actual recoveries for all ORT cases, we can estimate how much of the estimated ORT effect on established receivables had been translated into actual recoveries as of the end of ORT. This estimate of ORT savings is a substantial underestimate, as it ignores likely recoveries from established and expected receivables. To opt for this as a savings estimate is to make a complete concession to the arbitrary time at which the estimate is being made — i.e., well before most recoveries are received.

- Established receivables — This estimate of ORT savings is comprised of additional receivables reported in CIMS for *closed* cases. As an estimate of savings, this figure is overinclusive in one important respect: it counts as an ORT saving a possibly large number of dollars that will never actually be received (due to bankruptcy, default, etc.). At the same time, however, this estimate is underinclusive, as it does not include any expected receivables from pending cases that have not yet matured to the point where a receivable can be attached. The over- and under-inclusivity do not offset each other in any predictable way — there is no reason, for example, to assume that the opposing tendencies are equal in magnitude, yielding a result that is true on average. But however these tendencies resolve themselves, estimates based on established receivables provide an intermediate estimate of ORT savings from cases.

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28 Note that these case groups correspond to ORT1 and ORT2 case definitions in Appendix 5. There is an obvious third group of cases to consider: cases defined as "ORT cases" by OIG (ORT3 cases, in Appendix 5). The strength of this third definition is that it represents case by case judgments, by experts with detailed knowledge of the individual cases. The weakness of the estimate is that we cannot independently replicate the judgments nor apply the definition systematically to pre-ORT or comparison cases, based on information available to us. As a result, it is not practical to estimate the *incremental* effects of ORT, based on the ORT3 case definition.

- Expected receivables — These are the most speculative savings associated with ORT cases. They are comprised of our best guess of the receivables likely to be established for *pending or open* cases. For that purpose, as described in our Evaluation Design, we estimate the expected receivables of pending cases, conditional on how far the case has proceeded in the case development cycle. The expected receivables derived using this method give our best guess of the ultimate outcome of pending cases. But that guess must be regarded as being subject to a fairly high variance (see Appendix 5).

For all three types of estimates, our savings estimates are based on a double-difference adjustment of ORT impacts — i.e., an adjustment of post-ORT impacts to eliminate the savings that "would have happened anyway." We do so by making simple adjustments in the pre/post difference in ORT states, based on the pre/post comparison in non-ORT states. This methodology constitutes the most important difference between our savings estimates and the ORT effects inferred by DHHS in reports on ORT performance indicators and in certain public statements.[29] These DHHS reports describe total criminal and civil receivables and Medicare recoveries for ORT cases, but do not adjust these measures for what would have occurred without ORT. Our methodology is designed to focus on the incremental effects associated with the ORT initiative.

4.3.2 Savings from OI cases

Our estimates of the incremental effects of ORT on cases are summarized in Exhibit 13 below. Estimates range from a minimum of $4.1 million (the incremental recoveries for pure ORT cases only) to a maximum of $117.7 million (the incremental ORT effect, in terms of 1) recoveries and established and expected receivables, for 2) pure-ORT and ORT-influenced cases).

As is apparent from the exhibit, virtually all of the estimated receivables are from pure-ORT cases rather than ORT-influenced cases. More than 50% of the estimated impact is from expected receivables for pending cases. This is not suprising given that nearly 70% of the ORT-state, ORT period non-exclusion cases were still pending as of our data cutoff point (Exhibit 10). Any estimate that ignores that which has not yet happened — the establishment of receivables for many of the pending cases — is likely to miss a large part of the ORT effects on savings.

Because we do not know the percentage of established receivables that will ultimately be recovered by the government, it is not possible to provide a reliable point estimate of ORT savings. Instead, we present a range of potential ORT savings figures, based on:

- estimated recoveries to date, and
- established and expected receivables at different rates of collection on receivables.

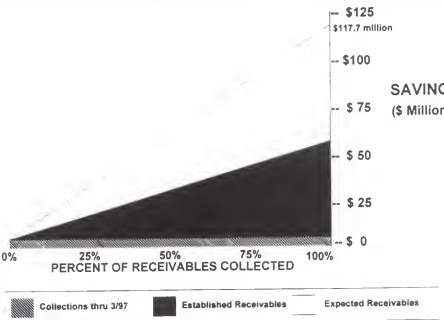
The important point in giving this range of the possible dollar savings from OI cases is that receivables are not true *savings*, and the collection rate, whatever it is, will be less than 100%.

But having made those points of method, it is essential to note that the estimated receivables from ORT cases are substantial, and the associated savings will be substantial so long as future collections (beyond dollars in the bank at the end of ORT) are included and so long as the rate of collections is non-trivial.

29 DHHS, "Selected Performance Indicators, Operation Restore Trust, March 1995 through March 1997," undated and DHHS, "HHS News: Secretary Shalala Launches New 'Operation Restore Trust'," May 20, 1997, p. 1.

Meanwhile, it is important to reiterate that these savings estimates are derived from cases only. While cases represent the largest source of savings we have been able to estimate, there are other components to consider in any summary comparison of savings and costs. We will be better prepared for that summary comparison after discussing audits, HCFA, AoA, and other ORT-related efforts.

Exhibit 13: ORT Impact Analyses
Incremental Receivables and Potential Associated Savings from OI Cases (Dollars in Millions)



What Counts as Savings	Cases Included in the Estimate [A]		Total for All Types of Cases
	Pure ORT Cases	ORT-influenced Cases	
"Money in the bank" — Incremental dollars actually recovered by the Trust Fund at the end of ORT [B]	$ 4.1	$ 0.5	$ 4.6
"Established Receivables" — Additional receivables reported in CIMS for closed cases[C]	$ 46.3	$ 5.4	$ 51.7
"Expected receivables" — Additional predicted receivables for open cases[D]	$ 57.9	$ 3.5	$ 61.4
TOTAL: All Types of Savings	$108.3	$ 9.4	$117.7

Notes A "Pure ORT cases" are cases that opened under ORT. "ORT-influenced cases" are cases that were opened before ORT but still pending when ORT started.

B The estimates of actual dollars recovered are based on HCFA data on actual recoveries in ORT cases as of the end of ORT (March 31, 1997). These estimates are double-difference estimates, in that they reflect an adjustment for recoveries that would likely have occurred in the absence of ORT.

C Receivables estimates are based on double-difference estimates of incremental ORT effects, minus the amount of recoveries. Established receivables are based on data as of May 31, 1997.

D Expected receivables are based on double-difference estimates of the incremental ORT effects on so-called "conditional expected recoveries" — i.e., on the predicted recoveries for cases still open that did not yet have an associated receivable as of the closing date of our CIMS data series (May 31, 1997).

Source Abt Associates Evaluation of Operation Restore Trust, 1997 (Final Report, Appendix 5).

Chapter 5
FINDINGS OF THE EVALUATION 2: THE EFFECTS OF ORT ON OAS AUDITS

Audits by the Office of Audit Services (OAS) are designed to identify investigative targets, develop estimates of questionable charges, and make recommendations to reduce the vulnerability of Medicare and Medicaid to fraud and abuse. Our analyses of OAS audits are based on three data sources: interviews with auditors in the central office and in the field (Appendix 1); a quantitative analysis of data in the Audit Information Management System (AIMS), the primary tracking system for OAS audits (Appendix 6); and a survey of audits, which represents auditors' abstracts of key characteristics of sampled audits (Appendix 8).[30] The message from these sources is fairly clear and consistent: ORT had a major impact on the volume and character of ORT-type audits. For OAS, ORT represents a change in:

- approach, toward more provider-specific audits,
- targets, toward more audits of the ORT subject types (DME, home health/hospices, and DME suppliers),
- process, toward more collaboration,
- techniques, toward more data-driven methods, and
- resources, toward more needed funding, particularly in travel.

This summary is fairly congruent with what ORT tried to accomplish.

It is interesting to note the contrast of these audit results to the results for cases (see Chapter 4 above). For investigators, the big difference ORT made was in collaboration and resources. ORT basically ramped up a slightly changed set of enforcement methods. By contrast, for OAS, ORT was a more fundamental change in technique and approach.

Before presenting these audit results, we should note an important limit on our evaluation of audits under ORT. As in our evaluation of cases, our evaluation of audits assumes that most audits are valid and that few innocent providers are harmed by them. Given that assumption, "more" audits are a positive outcome, in appraising enforcement efforts. However, since we did not talk to many providers or any provider organizations, it is fair to say that we did not explore that assumption.

5.1 OAS Audits: Volume and Character

*1. **ORT has resulted in a large increase in the number of audits of ORT-type providers.***

The increase can be measured in a number of ways.

30 The survey of audits does not include a usable pre-ORT sample of audits. The reason: there were few pre-ORT audits done in ORT states on ORT subject types; and for the few that were done, sample attrition (e.g., due to the retirement of auditors familiar with the audits) was relatively high.

By volume. ORT was associated with an extremely large net (double-difference) increase in the volume of audits of ORT subject-type providers (Exhibit 14). During ORT, 116 ORT-type audits opened across the five demonstration states, compared to only 17 ORT-type audits that opened in the 1990-1994 period.[31] Across comparison states, there were 30 audits each in the pre-ORT and ORT periods.

By OAS staff hours. Another way to examine changes in volume associated with ORT is to analyze OAS staff time spent on ORT-type audits. ORT clearly had a major impact on the priorities of OAS auditors. During ORT, 18,920 staff days were devoted to ORT focus-area audits in demonstration states, compared to 3,651 staff days in the pre-ORT period, an increase of 418%. In comparison states, auditors devoted 2,766 staff days to ORT-type audits during ORT, compared to 5,693 in the pre-ORT period, a decrease of 51%.

By subject type. There were large increases in volume in the ORT states for all four ORT subject types (Exhibit 15):

- DME audits increased from 2 to 19.
- Home health agency audits increased from 13 to 41. In addition, hospice audits increased from 0 to 11.
- Nursing home audits increased from 2 to 45 during ORT.

By state. The increase in audit volume associated with ORT was spread across all five demonstration states (data not shown). During ORT, Florida had the most ORT audits, but ORT was associated with a large increase in audit volume for four of the five ORT states. Illinois, which opened only eight audits of ORT subject- type providers, was the only state where ORT was not associated with a large increase in the volume of audits opened.

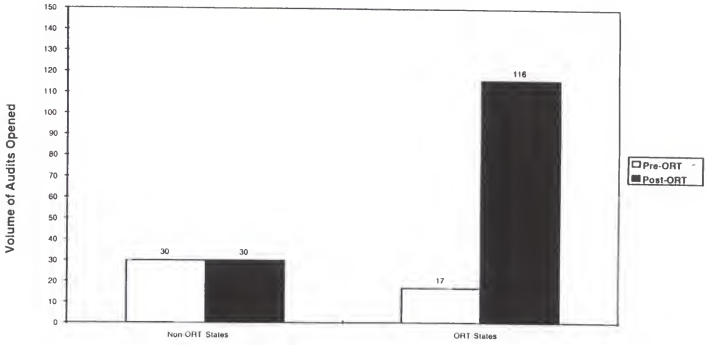
2. *OAS audits now place a greater emphasis on identification of fraudulent providers.*

Among other things, ORT represented an effort to reorient the purpose of OAS audits, from "program" audits to provider audits. The difference between the two types of audits is not just one of semantics, as the two types of audits are structured very differently.[32] According to our survey results (Exhibit 16), virtually all of the ORT-type audits were provider-specific: only 5% had the primary purpose of appraising the "policies, practices, and vulnerabilities of the Medicare program." Most of the audits surveyed were designed either to identify aberrant providers (56% of all post-ORT audits) or to identify questionable charges from specific providers (34%). A few of the audits (5%) were designed to assist an active

31 Note that for this report, we excluded audit records that appeared to have been established in AIMS merely for the purpose of recording ORT expenditures (e.g., audit records related to attending conferences and meetings). We also excluded audits that were canceled prior to completion or that had zero cumulative staff days.

32 This difference is perhaps best understood in terms of the samples that are drawn for the two types of audits. In a program audit, the sample drawn involves at most a few claims from each of many providers, thus permitting auditors to draw inferences about the prevalence of conditions or behaviors in the program. By contrast, a provider audit involves multiple claims from a single or few providers, thus permitting auditors to draw inferences about the prevalence of practices by particular providers. This latter capacity is of obvious relevance to enforcement efforts. ORT opted for doing more of the latter — and then using findings of questioned charges against a few providers (rather than program-level audits as such) to support discussions of program vulnerabilities. In that respect, ORT represented a more inductive approach to audit targeting and methods.

Exhibit 14: ORT Impact Analyses
Volume of Audits Opened



Source: AIMS (Data through April 1997)

Notes:

1. Includes ORT auditee types only (DME supplier, home health agency, nursing home, hospice).
2. Non-ORT states include all non-ORT states with an OI suboffice.
3. Pre-ORT period includes audits opened 1990-94; ORT period includes audits opened in 1995-97.
4. Excludes cancelled audits.

Exhibit 15. ORT Impact Analyses: Audit Volume by Auditee Type

Auditee Type	ORT states			Comparison states		
	Pre-ORT period	ORT period	% Change	Pre-ORT period	ORT period	% Change
DME supplier	2	19	+850%	2	3	+50%
Home health agency	13	41	+215%	21	17	-19%
Hospice	0	11	--	0	0	--
SNF	2	45	+2150%	7	10	+43%

Source: AIMS, 1997.

Exhibit 16. Survey of Audits: Primary Purpose of Audits

Response	% of Post-ORT Audits
Identify or target aberrant providers for audit and/or OI referral	56%
Identify questionable charges from specific provider(s) for recoupment and other follow-up actions	34%
Assist an active investigation	5%
Appraise policies, practices, and vulnerabilities of the Medicare program	5%
Other	1%
No answer	0%
TOTAL	100% (N=104)

Note: Total may not sum to 100% due to rounding

Source: Abt Associates, 1997

investigation.[33] Note that these results do not vary much by state: ORT audits in all five states are almost entirely provider specific (data not shown).

Our analysis of AIMS results suggests that the post-ORT level of provider-specific audits constitutes a large increase over pre-ORT audits (data not shown). ORT was associated with a large increase in the number of audits related to provider-specific purposes, such as program compliance, services provided/delivery systems, and alleged criminal activities.

An additional way to see this reorientation of audit approaches is by comparing pre- and post-ORT staff days per audit. This comparison allows us to measure whether ORT is associated with changes in the

33 This latter figure is almost surely an understatement, since audits of this type were especially vulnerable to being excluded from our survey sample due to confidentiality restrictions. See Appendix 8

complexity of audits, at least as measured by the intensity of staff resources. Of the complete audits in the two periods, ORT audits took an average of 122 staff days each, while pre-ORT audits from demonstration states took 190 staff days on average. There are still 46 ORT-period audits pending, which may increase the average number of staff days devoted to ORT-period audits, but these findings are consistent with what we learned from OAS auditors in the field: that the identification of aberrant providers involved using a smaller number of claims than audits focused on program vulnerabilities. As a result, ORT-type audits could have a faster "turnaround." Indeed, in California and New York, auditors spoke of developing methods for more rapid identification of fraud and referral of suspects to law enforcement agencies.

3. The added discretionary resources that ORT provided were especially helpful in OAS audits.

Auditors are much more likely than investigators to point to the value of added discretionary resources that ORT made available. As shown in Exhibit 17, one-half of all ORT-era audits were judged to have required unusual amounts of computer resources. In addition, approximately 90% of ORT audits used special data runs, of which nearly one-quarter were for targeting nursing homes, while 15% used HCFA data for targeting purposes[34] and another 15% used HCFA contractor data or the Common Working File (data not shown).

Auditors also highlighted the importance of ORT funds for travel. In 42% of these ORT-period audits, unusual amounts of travel were said to be required (see Exhibit 17). How much travel? Our survey data suggest that 60% of all ORT-era audits used "some" travel, and 22% used a "lot" of travel, while 16% used none (data not shown).[35]

Exhibit 17. Survey of Audits : Unusual Resources Required for Audit Development

Response	Percent of Post-ORT Audits
Computer resources	49%
Travel resources	42%
Medical review	38%
Staff time	35%
Communication costs	2%
Other	2%
None of the above	26%
No answer	4%
TOTAL	n/a N =104

Note. Respondents were encouraged to cite all aspects of unusual resource use, so rows are not mutually exclusive and percentages may not sum to 100%.

Source: Abt Associates, 1997.

34 This reference to HCFA and BDMS may refer to the HCFA Customer Information System (HCIS), an initiative in parallel with ORT to develop a user-friendly database that would permit analysis of relatively recent claims to highlight aberrant or outlier providers.

35 "Some" travel was defined as under 20 days of overnight travel. A "lot" of travel was defined as 20 days or more of overnight travel. It is interesting to note the contrast between audits and investigations. Specifically, 84% of the cases required no overnight travel, versus 16% of the audits; 14% of the cases required some overnight travel, compared to 60% of the audits; and none of the cases required a lot of overnight travel, compared to 22% of the audits. These survey data suggest that the ORT partner that most uses the added travel resources of ORT is OAS. One caution is in order, however. It is possible for the lesser OI travel in fact to be more *valuable* at the margin, even if audits consume more travel on average.

One of the more striking results shown on Exhibit 17 is that unusual medical review resources were judged to have been consumed in nearly 40% of all audits. This prevalence estimate echoes the comments in site reviews, about the greater use in audits of medical and clinical staffs from PROs, Medicare contractors, HCFA, and others. Under ORT, these staffs were said in interviews to be an integral part of the planning and execution of many audits, rather than as an add-on or sequel to a standard audit.

Overall, these data suggest that ORT's liberalization of resources was important to OAS. There is in these answers a more consistent citation of unusual resource needs in audits than in investigations (compare Appendix 7). There is also a slightly lesser claim of resource limits constraining enforcement: where case development was said to be limited by resource shortages in 27% of all ORT cases, that was true in only 22% of all audits (data not shown).

4. ORT was associated with a significant increase in collaboration in the initiation and development of audits.

Essentially all of our data from many different sources shows an increase in collaboration in the initiation and development of OAS audits. Auditors provided extensive examples in interviews — e.g., of collaboration with HCFA nurses in nursing home surveys. Our survey of audits (Exhibit 18) showed that 50% - 60% of the ORT-state/ORT-period audits involved at least some collaboration with HCFA and Medicare contractors to identify audit subjects. Over 23% of all audits involved some collaboration with OI. What is particularly interesting is that almost the same proportion of all audits (22%) involved collaboration with state survey and certification staffs. This result underscores how productive this particular federal-state linkage was. It is also a result that can fairly be attributed entirely to ORT, since the linkage of OIG auditors with state survey and certification staffs is without precedent before ORT.

By comparison to what we found for the initiation of audits, our results for the development of audits give heightened importance to one particular collaborator: the Medicare contractor. As shown in Exhibit 19, the Medicare contractor played a collaborative role in audit development in almost 60% of the audits, followed by HCFA itself in 47% of the audits.[36] The most notable other collaborators in the development of audits were state government staffs: survey/certification staffs (15% of audits) and Medicaid agency staff (13%). OI was involved in 11% of the audits. One interesting vestigial collaborator is Peer Review Organizations (PROs), which provide medical review expertise for audits (as they do for cases — see Appendix 7). In site visits, auditors mentioned that one particularly useful result of ORT was the ready availability of PRO medical reviewers to collaborate with auditors in the early stages and execution of audits. In 4% of the audits surveyed, state PRO staffs played a notable collaborative role.

Meanwhile, our analysis of audit tracking data showed important pre/post and demonstration/comparison differences in OAS' collaboration with two particular organizations (Exhibit 20):

- OI — Under ORT, 15 audits were opened to assist OI, compared to only 3 in the pre-ORT period. Each ORT state had at least two audits that were OI assists. New York opened five audits to assist OI investigations, the most of any ORT state.

- HCFA — In 15 audits, OAS joined HCFA and state certification agencies in reviewing Florida skilled nursing facilities. No evidence of similar collaboration could be found in other states or in the pre-ORT period.

36 Note that collaboration as defined in our survey was not restricted to one partner — i.e., was not mutually exclusive — so percentages do not add to 100%.

Exhibit 18. Survey of Audits:
Notable Collaboration in the Identification of Audit Subjects

Response	Percent of Post-ORT Audits
Medicare contractor	59%
HCFA	54%
OIG/OI	23%
State survey/certification staff	22%
OAS in another region	8%
State Medicaid agency	8%
OIG/OEI	4%
FBI	3%
U.S. Attorney's Office	3%
Peer Review Organizations	2%
Other State agencies	2%
Other Federal agencies	2%
Administration on Aging	1%
Long-Term Care Ombudsmen	1%
None	17%
TOTAL	n/a N =104

Note: Respondents were encouraged to cite all aspects of notable collaboration, so rows are not mutually exclusive and percentages may not sum to 100%.

Source: Abt Associates, 1997.

Exhibit 19. Survey of Audits:
Notable Collaboration in Audit Development

Response	Percent of Post-ORT Audits
Medicare contractor	58%
HCFA	47%
State survey/certification staff	15%
State Medicaid agency	13%
OIG/OI	11%
OAS in another region	10%
U.S. Attorney's Office	5%
Peer Review Organizations	4%
Other State agencies	3%
Other	3%
Medicaid Fraud Control Units	1%
Other Federal agencies	1%
FBI	1%
OIG/OEI	0%
Administration on Aging/Long Term Care Ombudsmen	0%
None	13%
No answer	3%
TOTAL	n/a N =104

Note: Respondents were encouraged to cite all aspects of notable collaboration, so rows are not mutually exclusive and percentages sum to more than 100%.

Source: Abt Associates, 1997

Exhibit 20. ORT Impact Analyses: OAS' Collaboration with OI and HCFA

Type of Collaboration and State	Pre-ORT period	ORT period
OAS Collaboration with OI		
ORT state	3	15
Non-ORT state	7	7
OAS Collaboration with HCFA		
ORT state	0	15
Non-ORT state	0	0

Note: Audits that involved collaboration between OAS and HCFA were identified by the presence of "part of HCFA survey team" in the audit description field.

Source: Abt Associates analysis of data from the OAS Audit Information Management System, 1997

In both cases, the small comparison state numbers were unchanged after ORT.

5. There is evidence that ORT-state/ORT-period audits were performed in part by the diversion of staff from non-ORT work.

As discussed in Chapter 3 above, OAS received only 2 additional staff under ORT. However, in the ORT states, ORT was associated with a very large increase in staff resources devoted to audits of ORT focus-area providers. Given the limited additional staff made available under ORT, some diversion of resources from other types of audits was necessary in order to perform these audits. This is an opportunity cost — the cost of OAS's emphasis during ORT on audits of DME suppliers, home health agencies, nursing homes, and hospices was the audits that were not performed because of the change in emphasis.[37] Our main findings (data not shown):[38]

- Volume — ORT was associated with an overall increase in audit volume. This was true in all five demonstration states. Thus, the opportunity cost does not appear to have come in the form of declines in aggregate volume. This may simply mean that the unit of account — an "audit" — changed in scope under ORT. Indeed, that is what our other data show (i.e., a shift toward shorter-term, quick-turnaround audits).

- Auditee type — The increase in audits of ORT focus-area providers appears to have come at the expense of a reduction in the number of audits of DHHS Operating Divisions, state agencies, health centers, and non-profit agencies — another way of saying that, by focusing more on provider-specific audits, OAS was doing fewer program audits.

- Output — ORT was associated with a large increase in OI assist work and in provider specific audits (e.g., reports on grantee/contractor operations). The opportunity cost: a

37 For the analyses described in this section, we included all audits that opened after 1990, except for those that were canceled or had zero cumulative staff days. The resulting file contains information on 5,988 audits.

38 See Appendix 6 for a detailed discussion of these issues.

decrease in audits with audit reports on departmental operations, nationwide audit reports, and pre-award cost proposal audit reports. For example, across ORT states, the number of audit reports on departmental operations declined from 104 to 3.

- Staff — There is evidence that staff within ORT regions and, to a lesser extent, non-ORT regions were diverted to ORT projects from non-ORT projects.

These diversions are not surprising. The added effort required to increase ORT volumes had to come from somewhere. It appears to have come from a decline in non-provider-specific audits, with staff diverted to the new emphases ORT embodied.

6. Overall, auditors viewed ORT as leading to important changes in how OAS performs its role.

For each of 104 post-ORT audits, we asked auditors how the audit would have been different before ORT. The question was open-ended — answers were not prompted by check boxes or other means. The results are shown on Exhibit 21.[39] They suggest that ORT made audits:

Exhibit 21. Survey of Audits:
How Would the Post-ORT Audit Have Been Different If It Were Pre-ORT?

Response	Percent of Post-ORT Audits
Different audit focus	47%
Collaboration in some form	35%
Audit would not have been done before ORT	21%
Data-driven methods for identifying subject	16%
Resources – Travel	11%
More active follow-up under ORT	8%
More unusual methods of audit development under ORT	7%
Resources – Other	7%
Resources – Staff	6%
Other aspects of identification different under ORT	3%
Management commitment	3%
No pre/post differences	14%
No answer	6%
TOTAL	n/a N =103

Note Respondents were given open-ended opportunity to respond, so some mentioned multiple differences. As a result, rows are not mutually exclusive and percentages do not sum to 100%. Note also one survey was excluded, due to a statement that this was a pre-ORT audit — a statement that makes it impossible to determine the meaning of answers about how the audit then differed from a pre-ORT audit.

Source Abt Associates, 1997

39 Note that no difference was inferred when respondents gave the following survey answers: some form of "there would be no change," some form of "don't know," and no answer

- more provider focused — Almost one-half of all audits (47%) would have had a different focus before ORT.

- more feasible — OAS wouldn't have done this audit before ORT — 21% of the audits simply would not have been done before ORT, in the auditors' judgments.

- more feasible — travel resources would not have been available before ORT— For 11% of the audits, adequate travel resources would not have been available before ORT.

- more collaborative — The collaboration that took place in fact would not have taken place in 35% of the audits. This figure can be thought of as a rough lower bound on the estimated incremental effects of ORT on collaboration in ORT-type audits.

- more data-driven — For 16% of the audits, methods would have been different in that they would not have been so data-driven.

By contrast, one in seven ORT audits would have been no different before ORT.

These observations provide a revealing summary appraisal of ORT and OAS. OAS auditors saw ORT as an innovation in technique, resources, and approach. That result comports more or less exactly with the findings of our process analyses (Appendix 1).

It is interesting to note the contrast to the results for the survey of cases (see Chapter 4 above). For investigators, the big difference ORT made was in collaboration and resources. The implication is that OI investigators saw ORT as a ramping up of slightly changed enforcement methods, while OAS auditors saw ORT as a more fundamental innovation.

5.2 The Impact of ORT on Qualitative Audit Outcomes

1. So far, ORT audits have led to positive outcomes in almost 70% of the audits.

Our survey of ORT audits permits us to summarize the results in some detail (Exhibit 22). Of the 104 ORT audits in the sample, 30% led to recoupment actions, 23% to referrals of some kind (e.g., to OI or the FBI), and 15% to other outcomes.[40] Only 30% led to none of the potential positive outcomes listed. With the passage of time, that 30% figure is almost certain to decline for audits as a whole, since: 1) 57% of the audits are not complete; and 2) some of the more successful audits are disproportionately excluded from the sample, for reasons of confidentiality.[41]

By state, the dispersion in outcomes was fairly wide. The proportion of audits with some kind of positive outcome ranged from 81% in New York, to roughly 60% for three states (Florida, Illinois, and Texas), and 38% for California (data not shown). By subject type, DME audits had the highest rate of positive outcomes (79%), followed by SNF audits (69%), hospice audits (57%), and home health and other (approximately 50% each).

40 Note that these items are not mutually exclusive

41 In other words, when the results of these latter audits are added back in, the proportion of audits without a successful result will tend to decline

Exhibit 22. Survey of Audits: Significant Audit Outcomes

Response	Percent of Post-ORT Audits
Recoupment	31%
Referral to OIG/OI	21%
Other outcomes	15%
Exclusion	3%
Formal Civil or Criminal Charges	4%
Referral to the FBI	2%
Identification of other providers to be audited	2%
None of these outcomes	28%
Don't know/no answer	11%
TOTAL	n/a N =104

Note: Respondents were encouraged to cite all significant outcomes, so rows are not mutually exclusive and sum of percentages may not equal 100%.

Source: Abt Associates, 1997

2. There are signs of active follow-up in the majority of audits.

Another area where ORT sought to improve on traditional practices was in the follow-up to audit efforts. In the past, it was thought, people working in these enforcement processes almost always failed to follow-up on the implications of their work in a proactive way. In critical ways, the process failed *to learn* in a purposeful way.

ORT involved at least a rhetorical commitment to changing that pattern. Our survey results do not identify changes as such. But we can characterize the activities in individual audits. As shown on Exhibit 23:

- Particular audits led to subsequent "audits of similar providers" in 49% of the audits.
- Auditors met with Medicare contractors or made written recommendations to change some aspect of contractor operations as a follow-up to 28% of the audits.
- Meetings with someone outside OIG were held in 19% of the audits, and written recommendations were submitted in 18% of the audits.
- There was no follow-up in 21% of the audits.[42]

These figures may represent a lot or a little of the kind of follow-up that ORT is seeking. (We have no clear baseline, as noted in Appendix B.) But these figures do seem substantial, especially if we allow for the fact that: 1) over half of the audits are not yet complete (see above), and 2) our sample is biased to exclude some audits that promise to be particularly productive, as they are involved in judicial and other confidential proceedings.

42 Note that the follow-up categories are not mutually exclusive, so the percentages do not add to 100%

Exhibit 23. Survey of Audits: Did the Respondent Take Any Follow-up Actions?

Response	Percent of Post-ORT Audits
Commenced audits of similar providers	49%
Met with a Medicare contractor or made written recommendations to change some aspect of contractor operations	28%
Met with an agency outside OIG	19%
Submitted written recommendations for policy changes	18%
Other follow-up	12%
No follow-up	21%
No answer	2%
TOTAL	n/a N =104

Note: Respondents were encouraged to cite all follow-up they had taken, so rows are not mutually exclusive and percentages sum to more than 100%.

Source: Abt Associates, 1997.

*3. **ORT is associated with an increase in OI-assist audits.***

ORT was associated with a large increase in the number of audits that involved audit assist work. These audits do not result in the issuing of a formal audit report, but rather a report that is issued internally, usually to assist either OI with a criminal investigation or HCFA with surveys of SNFs. During ORT, the proportion of audits with an audit-assist output increased to 31% in ORT states, compared to 18% of audits between 1990 and 1994 (see Appendix 6, Exhibit 6-6).

5.3 Preliminary Estimates of "ORT Savings" from OAS Audits

*1. **ORT is associated with substantial increases in questioned costs, although the exact figure is difficult to estimate, given data limitations and the timing of the estimate.***

OAS audits can result in two basic types of savings for the Medicare program:

- Recoveries — Audits can lead to savings in the form of recoveries, through the identification and subsequent collection of questioned costs by an audit.
- Prevented costs — Audits also can lead to program savings in the form of prevented costs, through policy recommendations and other means of identifying and correcting program vulnerabilities.

OAS' audit tracking system (AIMS) does not report either of these types of savings, but does report an intermediate savings figure: the questioned costs that are disallowed. As a savings estimate, these questioned costs are analogous to the "receivables" tracked for OI cases (see Chapter 4 above).

Unfortunately, however, we cannot move very readily from AIMS to a double-difference estimate of incremental questioned costs, never mind actual recoveries. The difficulties here are as follows:

- Disallowances are not formally reported in the AIMS dataset for suspended audits — i.e., for audits that have resulted in referrals for criminal investigation — Many audits that have identified questioned costs result in referrals to OI or other law enforcement agencies. Because these audits have effectively been placed on hold until criminal investigations are complete, no final report has been issued, and the disallowances identified by these audits are not reported in AIMS. *This problem has little impact on pre-ORT audits in ORT and comparison states, but substantial impact on ORT-period audits.*

  By the end of ORT, OAS reported that questioned costs in these audits totaled $81.0 million for the ORT states. We have no rigorous way to include these questioned costs in our estimates of the impact of ORT, since we have no audit-level information and no pre-ORT or comparison state information on these suspended audits, from which to develop a double-difference estimate of savings. Obviously, this is a very large omission — in our opinion, the largest single cost of scheduling our final report so soon after the end of ORT is that we have no way to fashion an estimate of the effects of ORT on these audits.

- Only a small number of non-suspended audits have identified questioned costs — For audits that get around the first problem (they are not suspended due to a criminal investigation), there is a problem of small numbers. A relatively small number of audits result in the identification of questioned costs, and that is too few audits to perform double-difference estimates without extremely large variances. We estimate that the final disallowances on these audits total $21.5 million.

By having to delete the suspended audits, we only have a small number of audits for estimation purposes. As a result, we are not able to develop reliable estimates of the impact of ORT on disallowances identified by OAS. At the same time, however, it is worth keeping in mind that ORT audits identified unreported questioned costs totaling $81.0 million, and that there were final disallowances of $21.5 million on audits that had not been suspended. Given the large increase associated with ORT in audit volume, it is likely that ORT will be associated with a large impact in OAS disallowances, once the complete results are known.

Chapter 6
Findings of the Evaluation 3: The Sentinel Effects of ORT

It is plausible to assume that criminals respond to changes in the probabilities of apprehension and the severity of punishments. This commonplace has profound implications for understanding the effects of ORT. Changes in the *prospect* of detection or prosecution associated with ORT may have deterred some potential wrongdoers from attempting to defraud the Medicare program in the first place. These "sentinel effects" or "deterrent effects" can leverage the consequence of enforcement actions. These effects could be substantial, dwarfing the size of immediately detected direct effects on OI cases (e.g., fines, overpayment recoveries, settlements, restitution, or judgements) or overpayments identified by OAS audits.

Because it is not possible to measure the volume of fraud and abuse directly from claims data, we must estimate sentinel effects indirectly, by examining changes in cost and utilization patterns over time. We seek sentinel effects in geographic areas and types of service where ORT enforcement activity is most concentrated.

Given the difficulty of measuring these effects, we have developed a range of outcome measures for estimating sentinel effects associates with ORT (see Appendix 9 for a detailed presentation of results):

- Lower bound estimate : Using conservative assumptions about ORT effects — notabiy, that they are entirely confined within the ORT states — and applying tests of statistical significance at conventional levels, we cannot say with confidence that ORT had sentinel effects overall. However, while the effects of the individual analyses are not statistically significant, they are *consistently* negative (i.e., ORT was consistently associated with a decrease in allowed charges). Furthermore, large and statistically significant effects are found in some states and for some narrowly defined measures.

- Upper bound estimate: If we do not confine ORT effects to the ORT states, and if we measure for effects from the full panoply of government initiatives in the ORT period, we find statistically significant negative effects for durable medical equipment (DME) and home health. The results for DME in skilled nursing facilities remain statistically insignificant.

Why might we relax the conservative assumptions? It is apparent from the data that *something happened to cost and utilization levels in ORT and non-ORT states alike during the ORT period.* These changes are likely due in part to ORT, but also to other government initiatives at this time. It is important to emphasize that, in the pre/post comparisons, the "sentinel effects" we are estimating are not for ORT alone, but rather for the composite of government and contractor initiatives. ORT's contribution is probably substantial — a judgment based on qualitative evidence — but there is no way to separate ORT's contribution from, say, the contribution of stepped-up efforts by Medicare contractors, U.S. Attorneys, and the FBI.

Regardless of our judgment on how to estimate these effects, it is important to keep in mind that our estimates track apparent immediate changes in provider activity. But we cannot estimate all the subsequent changes in provider behavior that may act to offset these immediate effects. No matter how creative we are, we are unlikely to imagine all the different ways that abusive providers will act to undermine more stringent enforcement. In essence, we cannot imagine all the different places we should

look for offsetting costs. Our estimates are incomplete to that extent and, as a result, do not translate directly into Medicare savings.

Nonetheless, the fact that we find significant effects at all, under *any* reasonable assumptions, has important implications for our evaluation. It suggests that government initiatives were achieving one of their principal goals: to disrupt abusive provider behavior.

6.1 Outcome Measures and Data Sources

Our sentinel analyses focused on the three major ORT focus areas: home health agencies, DME suppliers, and nursing homes. In each of these areas, we face a trade-off in choosing between broader and more narrowly-defined outcome measures. The advantage of the narrowly defined measures is that they are likely to show sentinel effects (if they occurred) most clearly. Their disadvantage is that they are less likely to register shifts in provider behavior that may have occurred to offset these sentinel effects. Fraudulent providers might adapt to ORT by entering new geographic or service areas thought to be safer from government oversight, and narrowly defined measures will not capture such shifts. While the broader measures would be more likely to capture some of these adaptations, they could also vary widely for many reasons unrelated to sentinel effects. Hence, sentinel effects would be more difficult to detect in the broader measures. A final consideration: ORT projects varied in their focus across the five ORT states. We might thus expect to find impacts in some service areas in some states but not in others.

We have therefore looked at both broad and narrowly-defined tracer measures, for both all ORT states combined and for each state individually. We have indeed tended to find greater sentinel effects in the narrower measures and in individual states.

All of the analyses described below were based on Medicare claims files, acquired through the HCFA Data Center. These files provided information on utilization and reimbursement rates from 1993 through 1996 (the latest claims available) for home health agencies, DME, and DME for beneficiaries with a Medicare-covered nursing home admission. The home health file was based on a 100% sample of claims, while the DME files used HCFA's 5% sample Standard Analytic File.

Outcome Measures for Home Health Agencies

The key outcome measure used to measure sentinel effects in the home health industry was *total home health agency reimbursement per Medicare enrollee at the Metropolitan Statistical Area (MSA) level.* Based on interviews and preliminary analyses,[43] we analyzed reimbursement levels associated with ORT separately for free-standing, for-profit agencies. ORT may be associated with larger sentinel effects for the subset of agencies that had high visits per beneficiary, on the assumption that abuses to be deterred are more prevalent in that subset. To measure sentinel effects for these outlier agencies, we identified agencies that ranked in the top 15% in total visits per beneficiary (by state and quarter). Reimbursement levels were then tracked over the next year to measure sentinel effects associated with ORT.

We also analyzed changes associated with ORT in the number (and percentage) of new and exiting agencies. These changes are proxies for possible declines in the number of new agencies (due to direct terminations and deterrence of new entrants) and for possible increases in the number of agencies that become inactive (due to deterrence of abusive business activities).

43 Preliminary analyses showed a positive correlation between home health reimbursement per beneficiary and the proportion of free-standing, for-profit agencies

Outcome Measures for DME Suppliers

The key outcome measure for estimating sentinel effects in the DME industry was *allowed charges per Medicare enrollee at the MSA level*. In addition to analyzing total DME expenditures, we separately analyzed four fraud and abuse-prone DME policy-related groups that were the focus of specific ORT projects: incontinence supplies, surgical dressings, enteral nutrition, and nebulizer drugs.

These four tracer items were selected because they were believed to be subject to high levels of fraud and abuse and were the most likely types of service for which ORT might be associated with sentinel effects. The Miami Satellite Office was active in developing policy proposals to limit abuse of the nebulizer drug benefit, at a time when allowed charges per beneficiary for nebulizer drugs were nearly four times higher in Miami than in the second highest MSA. Enteral nutrition and surgical dressings were service areas with a great deal of MSA-level variation in allowed charges per beneficiary, suggesting the possible presence of fraud and abuse. They were also the subject of several reports done by the Office of Evaluations and Inspections (OEI) in Philadelphia (see Appendix 1).

Outcome Measures for Skilled Nursing Facilities

Most ORT projects related to skilled nursing facilities focused on Part B claims provided to nursing home residents. For example, several ORT states did surveys and/or audits of nursing facilities with unusual amounts of DME and other ancillary expenditures. Our analyses were guided by the hypothesis that increased scrutiny of medical supply costs for nursing home patients might result in reduced DME expenditures for those patients. Rather than analyze total nursing home reimbursement, we analyzed how ORT affected *total allowed DME charges for patients with a Medicare covered nursing home stay in the 90 and 180 days following date of admission.*

6.2 Estimation Techniques

Our estimates of ORT effects rely on comparisons of outcomes observed in ORT states to those observed in a set of comparison states. The ORT states were deliberately selected for the likely impact of an ORT-style effort. Other states differ from the ORT states in important ways besides the presence of the intervention, making comparisons potentially problematic.

The set of 28 comparison states used in the analyses consisted of *all non-ORT states with an OI suboffice*, the same specification used in our AIMS and CIMS analyses. This ensures at least that the comparison states, like the ORT states, have a large, predominantly urban population. More rural states, such as Montana, Vermont, Idaho, Alaska, and Nebraska, are excluded. We also excluded Louisiana from our analyses, since it was subject to several direct, ORT-style interventions from the Dallas Regional Office.

Our main estimates of the sentinel effects of ORT were based on a double difference approach. In essence, the deviation of the outcome in the ORT states during the ORT period *from what would have been predicted, based on pre-ORT experience*, was compared to the corresponding deviation in the non-ORT comparison states. In simplest terms, the double difference model can be written as:

$$Y_{it} = b_0 + b_1 ORT_{it} + b_2 ORTSTATE_i + b_3 ORTYEAR_t ,$$

where Y_{it} is the outcome measure of interest for MSA i in year t,
ORT_{it} is an indicator that MSA i was in a state that was experiencing ORT in year t,
$ORTSTATE_i$ is an indicator that MSA i was in an ORT state, and
$ORTYEAR_t$ is an indicator that year t was in an ORT year (i.e., 1996 in our data).

The coefficient b_1 represents the estimated impact of ORT, that is, the difference between the actual outcome in an MSA that was experiencing ORT, and what would have been predicted for that MSA, given (a) that it was in an ORT state (which may have tended to have higher values of the outcome measure even in the pre-ORT period), and (b) that the year was 1996 (which may have been unusual in terms of the outcome measure even in non-ORT comparison states).

This simple model was modified in several ways. It seemed likely that much of the variation in the outcomes was due to underlying differences among the MSAs that comprised the sample. Furthermore, demonstration states may have been selected, in part, because they had experienced not only higher levels but also higher growth rates of both home health and DME costs. To account for the first of these factors, a so-called fixed effects term was added for each MSA. Each MSA thus had its own intercept, differences among which captured general differences among the MSAs in the pre-ORT period. These separate intercepts rendered the overall intercept and the ORTSTATE indicator moot, so those terms were dropped. To address the issue of growth, it was assumed that the outcome followed a time trend over the pre-ORT period that, absent ORT, would have continued through 1996. This time trend was potentially different in the ORT states than in the comparison states.

Incorporating these considerations led to our basic model for estimating the sentinel effects of ORT:

$$Y_{it} = [\text{Fixed effects}] + b_1\,ORT_{it} + b_2\,(YEAR_t - 1992) + b_3\,(YEAR_t - 1992)\times ORTSTATE_i + b_4\,ORTYEAR_{it}$$

The fixed effects, which were not of interest in themselves, were estimated implicitly. As before, b_1 represents the ORT sentinel effect. The other terms in the equation represent the linear time trend for all states, the differential linear time trend for ORT states, and any general (non-ORT) effects associated with the year 1996. Several variations of this model were also estimated, to test hypotheses pertaining to impacts in particular states and spillover effects of ORT projects.

An implicit assumption in the model is that no ORT sentinel effects occurred until 1996. While ORT officially started in April 1995, implementation of many ORT projects did not occur for several months. More importantly, it took time for word of ORT to spread to the provider community, and provider behavior could not be affected until providers learned about the potential consequences of ORT on their operations. It seemed more reasonable to treat 1995 as a pre-ORT year (and use it to help estimate the pre-ORT time trend) than to look for ORT effects in that year.

6.3 Principal Findings of the Double-Difference Model

Our first estimates of the sentinel effects of ORT are based on the double-difference approach. This approach credits to ORT *only* those changes that occurred in ORT states above and beyond those that occurred in comparison states at the same time. This assumption is conservative, in that it will fail to find ORT effects in those instances where ORT in fact had non-trivial:

- spillovers into non-ORT states.
- joint products with other initiatives coincident with ORT.

There is reason *a priori* to expect both spillovers (e.g., note the national publicity ORT received and the actual spillover of some ORT investigations and audits into non-ORT states) and joint effects (e.g., note the energetic federal initiatives in DOJ and elsewhere that were coincident with ORT). *Thus, these*

double-difference estimates are not necessarily more realistic than alternative estimates. They are instead our most conservative estimates, based on our most restrictive assumptions. They can be thought of as establishing a lower bound estimate of the true sentinel effects of ORT.

6.3.1 Home Health Care

General Trends. In the five ORT states and 28 comparison states included in our analysis sample, *1996 marked a turning point in the growth of home health expenditures* (Exhibit 24). Allowed charges per Medicare enrollee increased by 45% between 1993 and 1995 (an average annual rate of approximately 21%), but by only 3% in 1996. With respect to both level and growth rate of costs for home health, however, Texas was virtually unique. Reimbursement in Texas increased by 73% between 1993 and 1995 and by 18% in 1996, the fastest growth rate in the county.

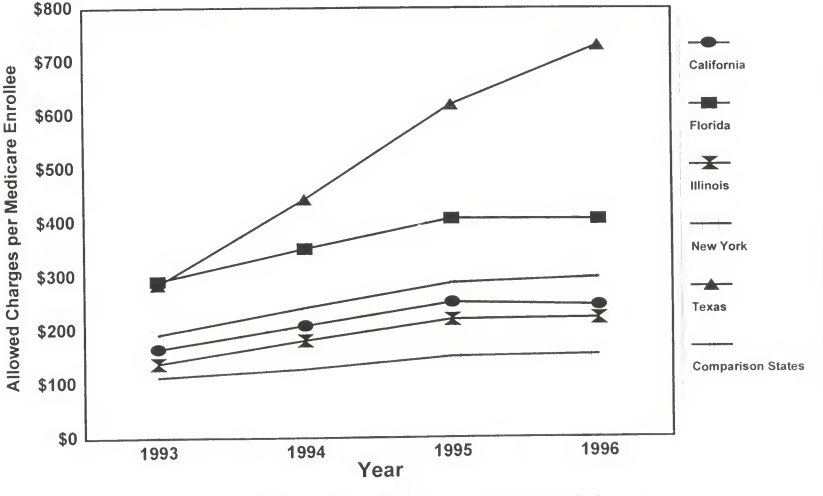
The percentage of providers that were new dropped steadily over the period, while the percentage of providers that were inactive remained roughly constant, between 3 and 4 percent. Total visits per beneficiary increased by 11% between 1993 and 1995, and then leveled off.

Estimated Impacts for All ORT States Combined. Because the comparison states experienced a leveling-off in the home care reimbursements in 1996 that was almost as great as that found in the ORT states, our double difference methodology fails to find statistically significant ORT sentinel effects for home care. For the five ORT states as a group, the estimated impact of ORT on overall HHA reimbursement per Medicare enrollee (-$4) was not statistically significant. ORT also had a small, insignificant impact (-$3) on reimbursement for free-standing, for-profit agencies. For agencies with high visits that ranked in the 80th percentile or above in visits per beneficiary (by state and quarter) in either 1994 or 1995, ORT was also associated with a negative but statistically insignificant impact on reimbursement per beneficiary (-$4).

Across the five demonstration states, ORT was also associated with virtually no change in the level of visits per HHA beneficiary. The effects of ORT on visits per beneficiary for free-standing, for-profit agencies were similar to those for all agencies.

For the subset of agencies with high visits per beneficiary, however, a larger impact was found: a decrease of 4.8 visits per beneficiary, statistically significant at the 10% level. Nationwide, in 1996, visits per beneficiary for the subset of high-cost agencies were about 10% less than in the pre-ORT period. These results suggest that, for all ORT states combined, sentinel effects may have been concentrated in outlier agencies — agencies with high rates of utilization and cost per beneficiary. Such a pattern is intuitively plausible, if we assume: 1) outlier agencies include a disproportionate share of fraudulent/abusive agencies, and 2) as a result, outlier agencies are more likely than agencies on average to change their behavior in response to stepped-up enforcement.

Exhibit 24. ORT Sentinel Analyses: HHA Allowed Charges per Medicare Enrollee (All Agencies)



Note: This chart is based on data for HHA allowed charges during the first 9 months of each calendar year.

Source: HCFA Home Health Agency 100% Standard Analytic File.

State-specific ORT effects. In each of the five ORT states, ORT had a negative, but insignificant, impact on home health reimbursement levels. In California, Florida, and Texas, ORT was also associated with negative, but insignificant, changes in reimbursement levels for the subsets of free-standing, for-profit agencies and for agencies with high visits per beneficiary. While ORT was associated with a reduction in total visits per beneficiary for every demonstration state except New York, the estimated effects were small and not statistically significant. Results for the subset of free-standing, for-profit agencies were similar to those for all agencies. In California, however, ORT was associated with a large, statistically significant reduction in visits per beneficiary for high-visit agencies. Visits per beneficiary for these agencies were about 20% less than they would have been in the absence of ORT. This last result suggests that the widely publicized and controversial home health efforts in California might have had a large impact on the outlier (high-visit) agencies in that state.

6.3.2 Durable Medical Equipment

Allowed charges for DME supplies increased steadily between 1992 and 1995, and there were especially large increases in allowed charges for selected types of DME and in Florida. Between 1993 and 1995, total DME charges rose by over $30 per Medicare enrollee, from $154 to $186 (Exhibit 25). Between 1995 and 1996, allowed charges grew more slowly. This slowing down perhaps reflects the DME-related activities of ORT. But it almost surely reflects as well the efforts of the maturing DMERCs and National Supplier Clearinghouse to assert more active control over the DME benefit.

Costs increased throughout the period for comparison states and for three of the ORT states (Texas, California, and Illinois). In Florida, by contrast, allowed charges rose steadily between 1993 and 1995, but declined during 1996. The level of allowed charges was much higher in Florida than for any other ORT state. In New York, which had the lowest allowed charges per enrollee among the demonstration states, allowed charges also declined slightly between 1995 and 1996.

Exhibit 25. ORT Sentinel Analyses:
DME Annual Charges Per Medicare Enrollee —
Nationwide Descriptive Statistics, 1993 - 1996

	Allowed Charges Per Medicare Enrollee						
Category	1993	1994	% change	1995	% change	1996	% change
Total DME	$154.25	$167.16	8.4%	$185.90	11.2%	$192.24	3.4%
Incontinence Supplies	$6.78	$6.75	0.0%	$3.67	-45.6%	$1.94	-47.1%
Surgical Dressings	$1.49	$1.81	21.5%	$3.05	68.5%	$1.48	-51.5%
Enteral Nutrition	$17.91	$16.73	-6.6%	$14.38	-14.0%	$13.52	-6.0%
Nebulizer Drugs	$7.07	$6.82	-3.5%	$9.77	43.4%	$9.94	1.6%

Note All "% change" columns are based on percentage change from prior year

Sources HCFA 5% Sample for the 100% Durable Medical Equipment Standard Analytic File

By contrast, the four selected DME sub-groups did not show such constant cost increases. In fact, between 1993 and 1996, costs per Medicare enrollee *decreased* for incontinence supplies (Exhibits 25 and 26). This decrease was largest in Texas , although there were declines in all ORT states in both 1995 and 1996. Incontinence supplies came under increasing scrutiny after the issuance of an OEI study that reported a

dramatic increase in payments for incontinence supplies to nursing facilities nationwide. These stepped-up enforcement efforts continued during ORT, with several criminal cases opened against distributors of incontinence supplies. During ORT, one of the country's largest suppliers of incontinent care products in the U.S. agreed to forfeit $32 million seized in bank accounts.

Allowed charges for enteral nutrition decreased substantially over this period (Exhibits 25 and 27). This decrease was due in large part to extraordinary decreases from extraordinary initial levels of cost in Florida, especially South Florida. From 1993 to 1994, allowed charges per beneficiary in Florida decreased from $52 to $49, while the much lower allowed charges per beneficiary nationwide decreased slightly (from $18 to $17 over this period).[44] But by 1996, allowed charges per beneficiary in Florida decreased to $12, a drop of over 75% to a level below the 1996 national average of almost $14.

Allowed charges for surgical dressings increased by 68% between 1994 and 1995, but fell by more than 50% between 1995 and 1996, to approximately the 1993 level (Exhibit 28). Among ORT states, allowed charges for surgical dressings nearly doubled between 1994 and 1995 in Florida, before declining sharply in 1996. For other ORT states, there is a smaller increase in 1995 and decrease in 1996. In 1994 and 1995, the DMERCs identified surgical dressings as a fraud and abuse-prone type of service, and initiated a number of efforts to control the benefit, especially for nursing home residents. The 1996 reduction in allowed charges for surgical dressings probably reflects a combination of efforts by the DMERCs and by the ORT partners.

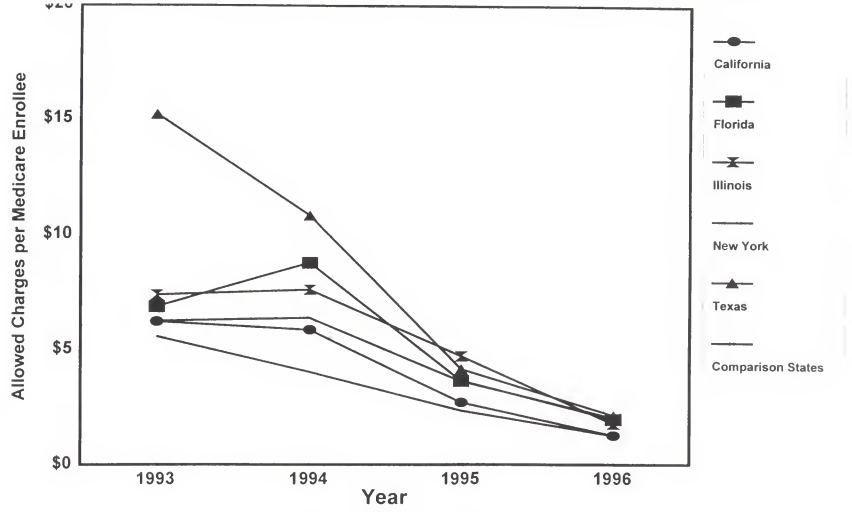
Allowed charges for nebulizer drugs fell between 1993 and 1994, but rose by 43% between 1994 and 1995. This increase was due in large part to aberrant nebulizer drug charges in Florida (Exhibit 29). In 1994, allowed charges per enrollee for nebulizer drugs were 200% higher in Florida than in comparison states, due primarily to Miami, where allowed charges were $145 per beneficiary, compared to $8 nationwide. Between 1995 and 1996, however, allowed charges for nebulizer drugs increased by only 1.6% nationally and declined sharply in Florida. However, Florida still remained well above other ORT and non-ORT states.

Estimated Impacts for All ORT States Combined. Across the five demonstration states, ORT was associated with a negative but not statistically significant impact on total allowed DME charges for all DME. With respect to the fraud-prone DME types we examined, significant ORT effects were found for two components. The estimated impact of ORT on allowed charges for *surgical dressings* was $1.40, a reduction of 46% from the 1995 mean of $3.05. ORT was also associated with a statistically significant reduction of more than $5 in allowed charges for *nebulizer drugs*, representing about 50% of the nationwide 1995 average of nearly $10 per enrollee.

ORT was associated with a positive and statistically significant effect (at the 10% level) on payments for *incontinence supplies*, but the effect in this case is in the opposite direction to what we would expect: a slowing down of the rapid decrease in allowed charges for incontinence supplies in the *pre-ORT* period, as shown in Exhibit 26.

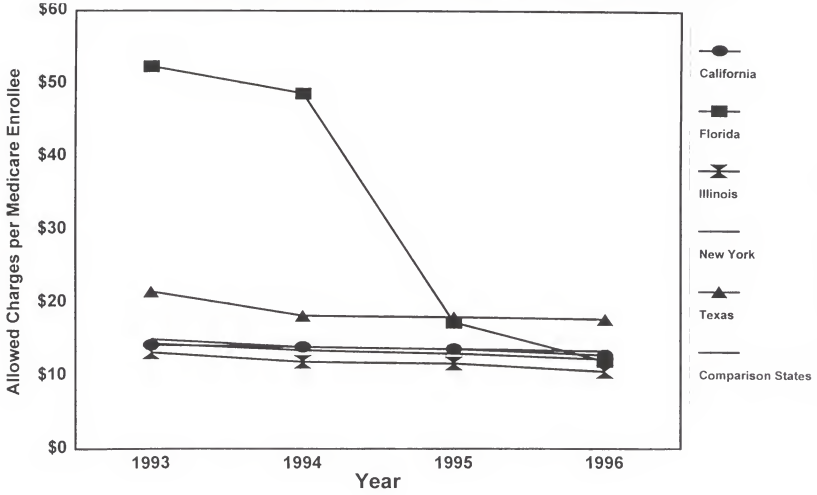
44 To get some idea of how high the South Florida costs for enteral nutrition were at this time, consider that allowed charges per beneficiary in Miami were $369 in 1994— nearly twenty times above the national average and by far the highest in the nation (specifically, almost 500% higher than Alexandria, Louisiana, the second highest MSA in the nation at $64).

Exhibit 26. ORT Sentinel Analyses: Allowed Charges per Medicare Enrolee for Incontinence Supplies



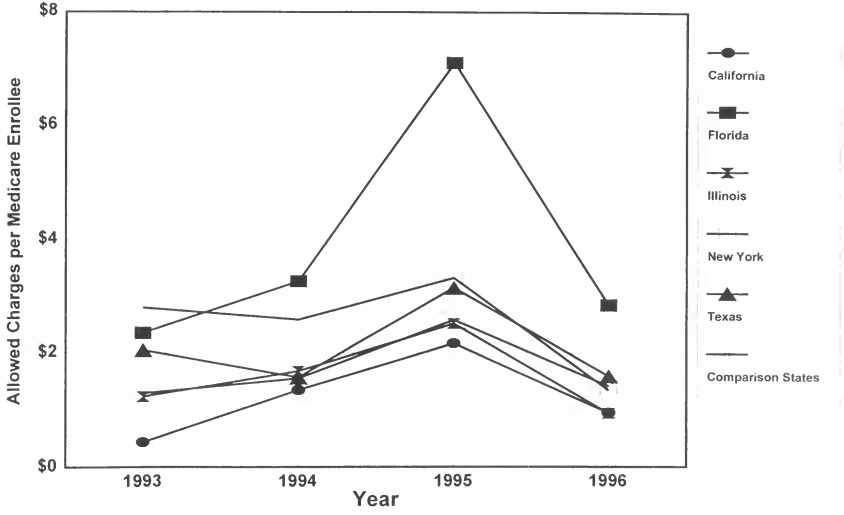
Source: HCFA 5% Sample of the 100% Durable Medical Equipment (DME) Standard Analytic File.

Exhibit 27. ORT Sentinel Analyses: Allowed Charges per Medicare Enrollee for Enteral Nutrition



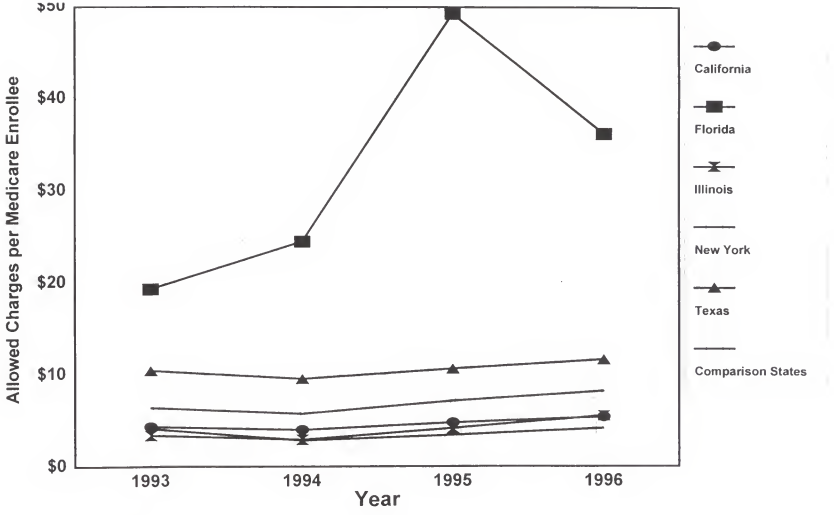
Source: HCFA 5% Sample of the 100% Durable Medical Equipment (DME) Standard Analytic File.

Exhibit 28. ORT Sentinel Analyses: Allowed Charges per Medicare Enrollee for Surgical Dressings



Source: HCFA 5% Sample of the 100% Durable Medical Equipment (DME) Standard Analytic File.

Exhibit 29. ORT Sentinel Analyses: Allowed Charges per Medicare Enrollee for Nebulizers



Source: HCFA 5% Sample of the 100% Durable Medical Equipment (DME) Standard Analytic File.

These DME results for all states combined underscore a point made earlier. With respect to these aggregate ("wide-screen") measures, the results we observe reflect effects from many different disturbances or interventions, not just the effects of ORT alone. This is not a surprising finding, given all the possible sources of disturbance in the trends and levels of DME costs. But notwithstanding how aggregated these measures are (i.e., they are not precise "tracers" of micro-effects), we nonetheless see changes in a substantial and negative direction at the time of ORT. While we cannot prove the point, our best guess is that the changes we observe are due to all of the different deliberate interventions at this time — including, most importantly, HCFA's establishment of the DMERCs, the SADMERC, and the National Supplier Clearinghouse two years before ORT. These new arrangements made it possible for HCFA to implement rapid, consolidated responses when stark problems were pointed out (e.g., when the SADMERC identified rapid growth in surgical dressing costs in 1994 - 1995). HCFA and its carriers never had this capacity before.

Thus, the presence of such interventions as the DMERCs has an important consequence for our estimates of ORT effects on DME: it tends to reduce the size and significance of those estimated effects. There are two reasons, both of which are related to the logic of the double difference (pre/post, demonstration/comparison) model. First, as national interventions outside the ORT states, such interventions as the DMERCs introduce negative trends in comparison states, with the result that the ORT state-comparison state difference is reduced. The estimated "ORT effect" is reduced as a result. Second, as pre-ORT interventions, these interventions prompt declines in some measures before ORT, thereby reducing the pre/post difference, and thus the effects attributed to ORT. We will have more to say on the meaning of this kind of confounding, when we discuss alternate methods for estimating sentinel effects (see Section 6.4 below). The important point to emphasize here is that this confounding creates reasons a priori that results for all ORT states combined are less likely to be statistically significant, even when there is a true ORT effect.

State-specific ORT effects. The results for state-specific effects are detailed in Appendix 5. We will briefly discuss those results here.

Across all types of DME, when ORT effects were estimated separately for each demonstration state, ORT had a large, negative effect in Florida that was statistically significant. ORT was associated with a reduction in DME allowed charges per enrollee of almost $30 in that state. This represents an 11% decline from Florida's 1995 level of $282 per enrollee. In the other four states, the estimated sentinel effects associated with ORT across all types of DME were small and not statistically significant.

For incontinence supplies, ORT was associated with a large, *positive* effect in Texas. This reflects the large decrease in allowed charges for incontinence supplies in Texas in the 1993-95 pre-ORT period, from $15 to $5 per enrollee. In 1996, allowed charges did not continue to fall at the same rate as they had in the pre-ORT period, when Texas had much higher costs than other states. Costs for incontinence supplies fell nationwide in 1996 (in comparison states, allowed charges were $1.02, or 29%, less than the level implied by the 1993-95 time trend).

The previously discussed sentinel effect found for surgical dressings was driven by large estimated ORT effects in Florida. In Florida, ORT was associated with a $4.50 reduction in allowed charges for surgical dressings, an estimated impact of more than 50%. The impact of ORT on allowed charges for surgical dressings was negative in the other four demonstration states, but significant only in New York.

The large sentinel effect found for nebulizer drugs was also due to a large sentinel effect observed in Florida. The magnitude of this Florida effect was remarkable: over $26 per enrollee. The decrease constitutes almost a 50% reduction from Florida's 1995 level of $49 in nebulizer costs per enrollee.

Fraud and abuse for nebulizer drugs was a major priority during ORT. In a real sense, the efforts undertaken to combat fraud in this area represent the ORT partnership model at its best. Data analysis performed by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) uncovered evidence of fraudulent and collusive billing practices by a large number of suppliers in South Florida and showed that DMERC Region C accounted for 67% of the nationwide payments for nebulizer drugs. Efforts by staff at the ORT-funded Miami Field Office, along with intensive studies by OEI performed in the Philadelphia Regional Office, led to a policy change in the Medicare Carriers Manual. This change provided that only entities licensed to dispense prescription drugs (i.e., pharmacies) could bill for nebulizer drugs. In addition, the DMERC introduced an edit into the claims processing system to detect instances when Medicare beneficiaries were being billed for combinations of drugs which could be harmful if taken together.

6.3.3 Nursing Homes

One reason nursing homes are vulnerable to fraud is that the Medicare reimbursement system pays for nursing home services under both Parts A and B, making it is more difficult for DHHS to identify and investigate inappropriate provider activities. This structural vulnerability is compounded by the lack of regulation of DME sales representatives by DHHS, poor oversight of the nursing home supply inventories (e.g., to detect stockpiling of supplies by nursing homes), and beneficiaries' lack of awareness of items billed under their Medicare health insurance claim (HIC) numbers.

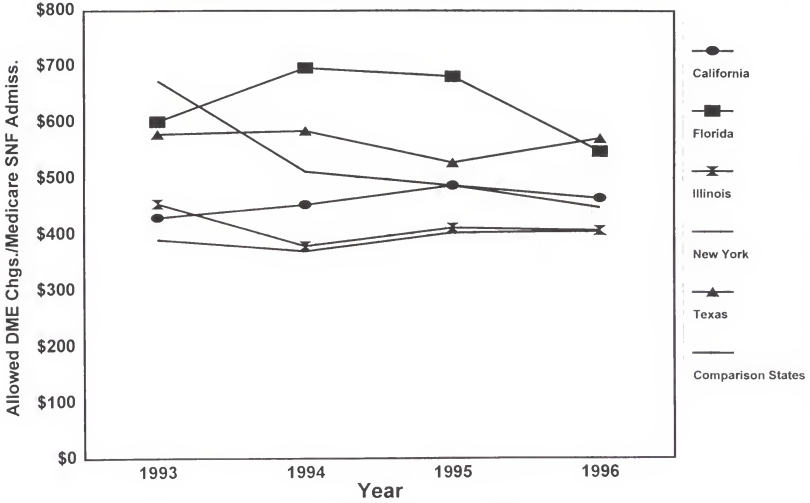
DME suppliers have been implicated in much of the nursing home fraud and abuse that has been identified by the OIG. While Medicare does not cover many types of DME for nursing home patients, covered items in nursing homes include surgical dressings, incontinence appliances and care supplies, orthotic and prosthetic devices, ostomy supplies, and enteral nutrition. It was therefore natural in our analysis to hypothesize that --- in addition to its impact on DME in general -- ORT would specifically reduce charges for DME used by Medicare recipients in nursing homes.

General Trends. Over the 1993-95 time period, the level of mean allowed SNF-DME charges in the 180 days following Medicare-covered SNF admissions was about $400 in comparison states, but substantially higher in the ORT states (Exhibit 30). The trend was negative, however: allowed charges in several ORT states, especially New York, declined markedly in the pre-ORT period.

Estimated Impacts for All ORT States Combined. For the five ORT states as a group, there was no significant sentinel effect on either average allowed DME charges per SNF stay or proportion of SNF stays with any allowed DME charges, within either 90 or 180 days of admission.

State-specific ORT effects. Pre-ORT trends in the individual ORT states were strongly negative in one state (New York), mildly negative in two others (Illinois and Texas), and positive in the remaining two (California and Florida). While average 180-day charges in four of the ORT states in 1996 are near the trend line adjusted for the observed increase in the comparison states in that same year, a major negative impact is seen for Florida: $208, statistically significant at the 1% level. The Florida effect, which represents a 47% reduction (relative to the national mean), is partially accounted for by a statistically significant reduction of 6.3 percentage points in mean allowed charges (around a national mean of 57% in the proportion of SNF admissions with any associated DME charges). Similarly large and statistically significant effects are seen for allowed DME charges within 90 days of a SNF admission for Florida.

Exhibit 30. ORT Sentinel Analyses: Allowed DME Charges Per (Within 180 Days of) Medicare SNF Admission



Note: This chart is based on data for SNF admissions during the first 6 months of each calendar year.

Source: HCFA 5% Sample of the 100% Durable Medical Equipment (DME) Standard Analytic File; and 5% Sample SNF Standard Analytic File.

Spillovers and Diversions Within ORT Regions. To test whether ORT projects led to either sentinel effects in nearby states (spillovers) or to displacement of fraud from the ORT states to their neighbors (diversion), the models were re-estimated with ORT regions replacing ORT states, and with the five ORT states deleted. There was little evidence of either net spillovers or net diversions for SNF-DME charges. The estimated effects were generally small and statistically insignificant.

These analyses failed to uncover evidence that ORT had any impact on DME charges following nursing home admission, except in Florida, where large effects for DME across all places of service were observed. This could be because there were no such sentinel effects, or that our measures and models were too imprecise to detect any sentinel effects that did occur. As noted above, the effects observed in Florida reflect the effects of ORT and other Florida-specific initiatives, such as those undertaken by the DMERCs, the NSC, and the Medicaid program in Florida. It is not possible to determine how much of this decrease is due to ORT and how much is due to these other programs.

6.3.4 Summary of Double-Difference Estimates

The analyses reviewed above are conservative: they assume that none of the decrease or leveling off of the rapid growth observed in the *comparison* states in 1996 was due to ORT. Furthermore, several of the outcome measures analyzed here were already falling rapidly in ORT states during the pre-ORT period. The double-difference methodology we used requires the decline to continue at the same rate or greater in 1996 in order to find an ORT sentinel effect.

Under this assumption, statistically significant sentinel effects were found for some highly focused outcomes in specific ORT states, but not for the broadest outcomes in all five states combined. Significant effects were found on:

- home health visits per beneficiary among agencies with especially high rates in 1994 or 1995 for all ORT states combined and for California;
- allowed charges for surgical dressings, for all states combined and for Florida and New York;
- allowed charges for nebulizer drugs, for all states combined and Florida;
- average allowed DME charges within 90 days and within 180 days of a Medicare-covered SNF admission, for Florida;
- proportion of Medicare-covered SNF admissions with any allowed DME charges within 90 days and within 180 days, for Florida.

Across all analyses, the great majority of estimated impacts were negative, but not statistically significant at conventional levels. While one cannot infer from a single statistically insignificant coefficient that a real effect has occurred, the consistent pattern of negative coefficients across the ORT states and outcome measures is highly suggestive.

The estimated sentinel effects for all ORT states combined are summarized in Exhibit 31 below as a percent of the 1995 mean value of the appropriate utilization measure. While all of the estimates are negative, none meet accepted standards of statistical significance. Hence there is no way of knowing whether they are indicative of true sentinel effects (obscured by background variation in costs and utilization) or are simply the result of random sampling error.

Exhibit 31. ORT Sentinel Analyses for Pooled ORT States: Estimated Sentinel Effects Using Double Difference Method

Home Health Reimbursement per Beneficiary	Home Health Visits per Beneficiary	Total Allowed DME Charges per Beneficiary	180-Day Allowed Charges for DME in SNF	90-Day Allowed Charges for DME in SNF
-1.4%	-1.3%	-3.4%	-8.5%	-6.5%

Note: None of these estimates is statistically significant at conventional levels.

Source: Abt Associates Evaluation of Operation Restore Trust (1997), Appendix 9.

6.4 An Alternative Approach: Pre/Post Comparisons

The results presented above assume that the behavior of providers in non-ORT states was unaffected by ORT. This approach is conservative in that it seeks to insure that no extraneous influences are mistakenly identified as arising from ORT, and thereby increases the likelihood that true ORT effects will be missed in our estimates. The underestimation of ORT effects will be especially serious if ORT effects on behavior were *not* limited to providers in ORT states, or if ORT was one of a set of interventions affecting ORT and non-ORT states alike which jointly produced the results we observe. Furthermore, using a double-difference approach reduces the precision with which ORT effects are estimated, because differencing causes the variance of estimators to grow.

As an alternative approach, however, suppose that we assume that providers in ORT and non-ORT states would have continued to follow their pre-existing trends, in the absence of ORT *and other enforcement initiatives that occurred during the ORT period*. Under this assumption, any changes from the trend observed in the ORT period in the comparison states can in fact be attributed to ORT and these other initiatives. If the earlier counter factual was conservative in its efforts to assure that no extraneous influences were counted as ORT effects, this alternative counter factual risks confounding ORT effects with a variety of non-ORT effects. These non-ORT effects would include economy-wide and industry-level events. As with the double-difference approach, this alternate approach is not necessarily the most realistic approach to follow. It is, instead, simply a better way to detect the sentinel effects of ORT + complementary initiatives, if such effects do in fact exist. But there is a price to pay: the alternate method increases the likelihood of finding significant effects where in fact there are none. One way to think of these alternate findings is that, by relaxing our more restrictive assumptions, they represent an upper bound on the likely sentinel effects that actually occurred.

Using this alternative, pre/post method, sentinel effects for home health are much larger than previously estimated and are statistically significant (Exhibit 32). The sentinel effect for DME is somewhat larger than the earlier estimate and is now statistically significant. The effect for DME delivered to nursing home residents is lower in magnitude and remains statistically insignificant.

Exhibit 32. ORT Sentinel Analyses:
Estimated Sentinel Effects Under Alternative Counter factual (Pre-Post Method)

Home Health Reimbursement per Beneficiary	Home Health Visits per Beneficiary	Total Allowed DME Charges per Beneficiary	180-Day Allowed Charges for DME in SNF	90-Day Allowed Charges for DME in SNF
-13.0%**	-6.6%**	-4.4%**	+1.2%	-3.3%

** Estimate is statistically significant at the 5% level.

Source: Abt Associates Evaluation of Operation Restore Trust (1997), Appendix 9

The alternative counter factual provides a much firmer suggestion of sentinel effects, at least for home health and DME outside of nursing homes. As for the appropriateness of this assumption, there are at least three reasons to believe that the indirect effects of ORT and other government and contractor initiatives on provider behavior may have been almost as great in non-ORT states as in ORT states.

First, non-ORT providers had little reason to think they were safe. By 1996, audits and investigations of home health agencies and DME suppliers were prominently featured in the trade press. To our knowledge, none of these articles or reports suggested that providers outside the five ORT states were *protected* from such investigations. Meanwhile, some of the ORT audits and investigations in fact extended to non-ORT states, placing non-ORT providers directly at risk.

To get some idea of the possible state-of mind of non-ORT providers, consider what one home health provider from a non-ORT state said to us in a phone interview in early 1997:

> "[Home health agencies are] under fire from the government. I think the government is succeeding in its objective; it's scaring the pants off of us providers...."

A second provider said to us:

> "... I do a lot of reading [trade journals, industry reports, etc.] and you see an increased amount of publicity regarding efforts to detect and stop fraud and abuse.... I think efforts are more intense. Given the amount of publicity around many of the efforts, you would be led to believe that efforts have intensified."

These fragments (plus some of our more general difficulties interviewing providers, noted in Appendix 10) suggest that, by the late ORT years, provider thinking in non-ORT states had been affected by the panoply of government initiatives then under way.

A second reason for taking the pre/post comparisons seriously is that there was no obvious, alternative explanation unrelated to fraud and abuse enforcement to explain the patterns we observe. Important non-ORT influences on Medicare utilization, such as trends in managed care, legislated alterations in benefits, or changes in the demographic composition of the Medicare population, did not exhibit evident sharp changes in 1996.

A final reason is that other, parallel efforts to control fraud and abuse were substantial. These include the work of the South Florida Task Force, the DME Regional Carriers and other activities carried out by Medicare carriers and fiscal intermediaries, expanded FBI activities, and large increases in the staffs at U.S. Attorneys' offices devoted to health care fraud. The fact that we cannot tease out the strictly

independent ORT effect in this group does not mean that this portfolio of activities did not have sentinel effects.

It is therefore reasonable to suggest that ORT *and other initiatives* may well have been the salient influence leading home health and DME providers to alter their behavior in 1996. By extension, the sentinel effects reported in Exhibit 32 have a claim to believability, although they must surely be regarded as upper bounds to the true sentinel effect: 13% for home health care and 4% to 5% for DME outside of nursing homes. These percentages could potentially translate into reduced Medicare expenditures in these narrow areas as large or larger than any of the other savings figures we discuss in this evaluation, although we cannot at present estimate all of the possible ways that providers might offset these reductions. In addition, we cannot say how long the deterred behavior will continue to be deterred.

As a result, these sentinel effects might not result in *real savings* to the Medicare program. But the sentinel effects that we have found may still be important in their own right. The point of enforcement efforts is not merely to achieve "savings," but to trouble and hassle dishonest providers[45] sufficiently to make health care fraud less worthwhile. The possible sentinel effects we have found are a sign that providers are feeling some hassles from the rejuvenated enforcement efforts associated with ORT and other initiatives.

45 As noted at the beginning of our analysis of cases (Chapter 2), such hassles are not necessarily restricted to dishonest providers.

Chapter 7
Findings of the Evaluation 4:
The Effects of ORT on Processes of Enforcement

Could Operation Restore Trust make different agencies work more closely together? And would closer collaboration make efforts to reduce fraud and abuse more effective? In our Interim Report,[46] we offered a series of relatively affirmative answers, including:

- The ORT partner agencies are collaborating more closely on fraud and abuse issues than in the past.
- Evidence of this collaboration is wide ranging and includes substantial initiatives between OI and OAS, federal regional officials and state agencies (e.g., federal and state survey staffs), regional agencies and Medicare contractors, and others.
- Linking AoA with HCFA and the OIG was a good idea, but the linkage is not yet fully worked out.
- The integration of different skills on the same team—such as those of nurses and auditors—has been effective.
- With ORT, HCFA has taken a more vigorous role in combating fraud and abuse. HCFA has now become more *directly* involved in the detection and enforcement effort against fraud and abuse.
- The effects of the demonstration on agency roles and collaboration are artificial. Walls between agencies could easily return, and few can describe how a return to the status quo ante will be avoided, except as they profess a "belief" in the partnership model.
- After ORT is over, the process will lose much of the energy ORT has created, unless there is timely feedback to encourage proactive *routine* efforts, outside the artificial limelight ORT has created. Our sense from interviews in the regions is that these issues are not yet resolved.

Our final results are consistent with these earlier conclusions. But considerable room remains for improvement, and we will use this Final Report to step back and summarize our additional conclusions in this area. We also will speak in somewhat greater detail about two areas that were postponed in our earlier report: processes of policy change under ORT, and the role of the OIG's Office of Evaluation and Inspections in the demonstration. The chapter is organized as follows:

1. The effects of increased collaboration among the ORT Partners
2. ORT and the processes of policy change
3. Office of Evaluation and Inspections

46 Abt Associates, Evaluation of Operation Restore Trust: Interim Report, report submitted by Abt Associates to the Health Care Financing Administration pursuant to HCFA Contract No. 500-92-0014 (November 15, 1996), section 4.4

5. The Administration on Aging

6. Medicare Contractors

7. The Department of Justice and the FBI

For detailed state-specific results (including the results of our analyses of two non-ORT comparison regions), see Appendix 1.

7.1 The Effects of Increased Collaboration among the ORT Partners

Operation Restore Trust was intended to improve collaboration among the many organizations that have some responsibility for control of Medicare and Medicaid fraud and abuse. In each ORT state there were probably 15 to 20 different organizations with substantial involvement. Exhibit 33 shows these organizations and some of the relationships among them.

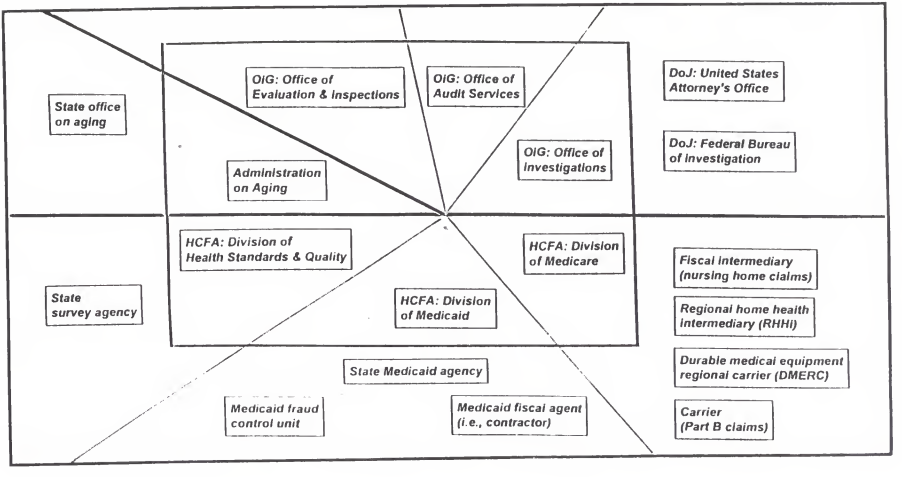
Under ORT, there were deliberate efforts to force collaboration among agencies for which collaboration was difficult, whatever sense it otherwise made. Encouragement of collaboration took several forms under ORT. The encouragement began with formal mandates from high-level officials, reaching up to the President and the Secretary of DHHS. These mandates were backed by centralized control of funding, kick-off conferences, the establishment of inter-agency teams in each ORT state, monthly teleconferences with each of these inter-agency teams and high-level managers in Washington/Baltimore, and other devices (e.g., a Miami satellite office for HCFA, to improve coordination of anti-fraud efforts in the South Florida area).

Our evaluation found extensive evidence that ORT resulted in more collaboration among the organizations shown in Exhibit 33. This result was not true always and everywhere, nor can its continuation be assured (on which, more will be said in Chapter 10 below). In general, the more difficult links to make were those that crossed either the solid or the dotted lines in Exhibit 33. Which links were improved varied from state to state, depending on the personalities involved, the historical relationships between different organizations, and the particular fraud challenges at hand. As an approximation, there were probably three or four links in each state that improved.

In Florida, for example, the HCFA Division of Medicare worked more closely with both the Office of Audit Services and the state Medicaid agency. In New York, the Office of Investigations and the state ombudsman's office developed ties where none had existed before. Also in New York, the state Medicaid agency worked with the Division of Medicare, the durable medical equipment regional carrier (DMERC), and OEI in Philadelphia in ways that had never been done before. In Texas, the Office of Evaluations and Inspections developed ties with HCFA's Medicare Division in pursuing an ambitious portfolio of nursing home studies. In all states, any ties between the OIG or the Division of Medicare, on the one hand, and AoA or the Division of Health Standards and Quality (DHSQ), on the other hand, were new, since AoA and the Division of Health Standards and Quality had not previously been involved in anti-fraud efforts.

Many other relationships were either unaffected or affected very little by Operation Restore Trust. With the exceptions of Florida, New York, and Texas, collaboration was not notably closer between OEI and the other components. Except in New York and Florida, Operation Restore Trust appears to have largely bypassed the Division of Medicaid and state Medicaid agencies. And though HCFA contractors certainly contributed to Operation Restore Trust, contractors' primary working relationships continued to be with the Division of Medicare and the Office of Investigations. In Florida, the U.S. Attorney's Office worked much more closely with the Division of Medicare than it did before ORT, but in general the USAOs and the FBI continued to work primarily with the Office of Investigations.

Exhibit 33
Organizations Responsible for Fraud and Abuse Control



In many instances across the ORT states where collaboration did improve, there is strong evidence that it resulted in better outcomes. The leading example may be the multidisciplinary teams that reviewed home health agencies and skilled nursing facilities. The typical team included an OAS auditor, a DHSQ nurse, and a nurse from the state survey agency. Previously, audits by OAS had been strictly financial while previous surveys had been strictly clinical. But reviewing both aspects allowed the teams to question whether payments were for care that was medically necessary and met Medicare standards.

The uneven nature of the increases in collaboration did not necessarily indicate an underlying problem with ORT. Anyone who thought that all of the agencies shown in Exhibit 33 could be brought together frictionlessly was engaged in wishful thinking. Moreover, there was no point in cooperation for its own sake. If cooperation did not reduce fraud and abuse, the effort would be wasted.

Yet there remains room for further increases in collaboration, and for those increases to be productive. Moreover, the formidable obstacles listed above mean it will take continued effort simply to prevent the gains *already* made from being lost. A small but telling example is that some ORT documents referred to collaboration between OIG and HCFA as "bipartisan"—as if Capitol Hill were a model for cooperation between two agencies within the same department. More substantively, planning for the post-ORT period, in which additional funds would be available thanks to the Kassebaum-Kennedy legislation, appeared to have taken place with only modest consultation among the ORT partners. In another example, one senior HCFA official told us OIG would find increased access to Medicare's claims data useful but "if OIG wants it they can pay for it." The new ways of doing business under ORT meant personnel in different agencies had to share information more freely, to adopt other people's priorities as their own, and to find more effective ways to allocate "credit" when credit should be allocated.

In the following sections, we review some of the more important results for enforcement efforts in home health, skilled nursing facilities, and durable medical equipment.

7.1.1 ORT Activities Related to Home Health Agencies

Home health enforcement initiatives were the centerpiece of Operation Restore Trust. Of all the ORT focus areas, these activities received the most consistent attention across the five ORT states. Moreover, the approach taken to fraud and abuse enforcement in this area was different in more ways because of Operation Restore Trust than was the case for the other ORT focus areas.

HHAs drew this attention for many reasons (not least because home health care had been the fastest growing component of the Medicare program in recent years, and because — before ORT — a paradigmatic federal-state collaboration in Texas showed how the effort could begin). The more important HHA initiatives were as follows.

- Expanded audits — These reviews were unlike those done previously by DHHS. First, the focus was on specific providers rather than program-wide behavior (see Chapter 5 above for a discussion of the significance of this difference). Second, suspicious providers were identified through an analysis of claims data that identified providers with unusually high costs per beneficiary or visits per month. Third, audits were more investigational in nature than past audits. Fourth, both financial and clinical data were examined. Fifth, the review teams included clinical personnel from DHSQ and the state survey agency, not auditors alone.

- Expanded surveys — Federal and state officials have responsibility for inspecting home health agencies to see if they meet the conditions for participation in Medicare, but in the past the emphasis has been very much on the quality of care. Under Operation Restore

Trust those inspections (or surveys) were expanded to include indications of possible fraud and financial abuse.

- Evaluation reports — To understand the vulnerabilities associated with the management of home health agencies, OEI studied a subset of provider agencies in the five ORT States with questionable billings.[47] Based on this inspection, on a major OAS audit, and on other factors (notably, widespread dissatisfaction with home health benefit safeguards), the President issued a six-month moratorium on certification of new home health agencies for participation in the program. This moratorium is designed to allow HCFA to develop appropriate safeguards to protect the program against abusive providers.

- Investigations — A number of the HHA expanded audits and expanded surveys resulted in referrals to the Office of Investigations as possible fraud cases (note that ORT was associated with a 167% net increase in home health cases, as discussed in Chapter 4 above).[48]

- Four-state audit — The expanded audits and expanded surveys described above were purposefully targeted at aberrant providers, making it impossible to generalize about *underlying rates* of inappropriate behavior. To develop a more general estimate, OAS in California, Illinois, New York, and Texas collaborated in a study designed to estimate underlying rates of fraud and abuse among HHAs in the four states. The audit found that 40% of Medicare payments for home health care should not have been made. A similar statewide random sample in Florida in 1994 found that 26% of claims were not eligible for payment.

- Cost report audits — In New York, auditors from the OIG and the fiscal intermediary inspected the home office costs of a large home health agency chain. This audit marked a new level of collaboration between the OAS and the fiscal intermediary. (Such collaboration is significant since, even if OAS identifies overpayments, only the fiscal intermediary can recover them.) Field audits of related organizations were done even though they were in another state (an unusual collaboration).

Except as noted, each of these initiatives was virtually without precedent before ORT. The home health initiatives epitomize the kind of broad-based, purposeful attack on fraud and abuse that ORT was designed to accomplish.

7.1.2 ORT Activities Related to Durable Medical Equipment

Unlike providers of home health care, nursing home care, and hospice care, many of the DME providers involved in fraudulent activities make little effort to become actual health care providers. They use post office boxes, fake identifications, and other tools of the common criminal. Accordingly, the DME activities under Operation Restore Trust were more likely to be investigations and less likely to be audits and surveys than was the case for the other focus areas. The more important DME initiatives were as follows:

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47 DHHS/OIG/OEI, "Home Health: Problem Providers and Their Impact on Medicare," Inspection No. OEI-09-96-00110, July 1997

48 The 167% figure is a net increase, in that it is the double-difference estimate of the ORT-related increase in home health cases. See Chapter 4 above

- Investigations — ORT was associated with a 146% net increase in DME cases, as noted in Chapter 4.[49] In most other respects, however, Operation Restore Trust had minimal effect on the *conduct* of the investigations.

- Data matches — In New York, the Medicaid and Medicare programs (through the DME regional carrier) cooperated in an initiative to match DME claims submitted to the two programs. Moreover, a routine monthly exchange of claims data was put in place so that the incidence of inappropriate payment in the future could be reduced.

- Studies and policy changes on provider numbers. Given the fly-by-night character of some DME providers, tighter control over provider numbers was an obvious — but still not straightforward — method of discouraging fraud and abuse. In Florida, the Medicare program increased its efforts to ensure that numbers were given only to legitimate suppliers. OEI also conducted a study of applicants for new provider numbers in the ORT states. After ORT ended, the Administration announced moves to tighten the standards for DME providers.

These activities were particularly important in California, Florida, and New York.

7.1.3 ORT Activities Related to Skilled Nursing Facilities

The issue with skilled nursing facilities is not the skilled nursing benefit itself but rather all the services and supplies that nursing home residents receive. The concern is that many ancillary services—such as physical, occupational, speech and psychological therapy—are provided when they are unnecessary. The SNF-related activities of ORT included:

- Data matches — In Texas and New York, ambitious efforts were made to match claims from different Medicare and Medicaid databases to construct profiles of the services used by residents of different facilities. In New York, the match was the product of unusual state-federal cooperation. In Texas, it was the result of an ambitious OEI initiative.

- Expanded surveys — As with home health agencies, survey protocols for nursing facilities were expanded to include indications of fraud and abuse, and federal-state surveys were undertaken. In one New York facility, for example, ORT surveyors found 94 residents who had received extensive psychiatric/psychological services, even though they had histories of dementia.

- Studies — About 18 studies during Operation Restore Trust examined the services provided to nursing home residents. The studies addressed issues at the national level. Unlike the focused HHA studies, however, the SNF studies covered a wide range of topics, including mental health services, durable medical equipment, prescription drugs, ambulance services, and imaging services.

- Expanded audits — In Florida, 16 audits were conducted that examined the medical necessity of ancillary services provided to nursing facility residents. In a break from previous procedures, the review team included an OIG auditor, a nurse from the state survey agency, and a nurse from the Division of Health Standards and Quality.

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49 The 146% is a double-difference estimate

- ORT states SNF audit — In each ORT state, one SNF with unusually high costs per patient was selected for an in-depth audit. As with other ORT projects, 30 beneficiaries were selected at random from each facility and the medical necessity of the claims submitted in their name was examined. For these 150 beneficiaries, $0.9 million in inappropriate payments were identified; by extrapolation, about $12 million inappropriate payments had been made to just those five facilities.

Overall, while there were fewer initiatives addressed to SNFs than to other ORT subject types, these projects were in many respects more challenging than the HHA projects. Most important, the analysis of claims data in the SNF projects was much more difficult than it was for the HHA projects, since it was necessary in the SNF projects to link Part A and B claims and (in some cases) Medicare-Medicaid claims. The linkage of those claims, while not technically infeasible, had never been done in enforcement activities before ORT.

7.1.4 ORT Activities Related to Hospices

Operation Restore Trust might be said to have "three and one-half" focus areas, and the hospice benefit would be the one-half. Hospices were the most important ORT focus area in Illinois. The other four states did some work on hospices but their primary emphasis was on HHAs, nursing facilities, and DME. The main hospice initiatives were as follows:

- Expanded audits — The Illinois ORT team took the lead in conducting expanded audits of 12 hospices in the ORT states that had unusually high numbers of long-stay beneficiaries. The audits combined on-site examinations of financial records and medical reviews by peer review physicians who focused on the beneficiaries' eligibility for the hospice program. In the 12 hospices, about 65% of the beneficiaries were found to be ineligible for the benefit in the first place. Medicare payments for these beneficiaries were about $83 million. Several hospice providers were referred for investigation of possible fraud. ORT teams in California, Florida, and Texas also participated in these 12 audits.

- Expanded surveys — In Illinois, California, and New York, survey protocols for hospice programs were expanded to place more emphasis on the eligibility of enrollees for the benefit and on other issues related to the appropriateness of submitted claims. Results from these surveys led to several hospice programs being referred to OI for investigation.

- Investigations — The audits and surveys described above resulted in several referrals for investigation, as noted. By the end of Operation Restore Trust, however, no civil or criminal proceedings had been initiated.

- Studies — OEI performed three related studies on hospice services provided to residents of nursing homes. The studies were in draft form at the end of Operation Restore Trust.

- Medical appropriateness of transfers — In Florida, the peer review organization reviewed a random sample of 30 transfers from HMOs to hospice programs, and found that 50% were inappropriate.

These hospice initiatives came about both due to the close relationship of the hospice and home health benefits (that relationship made these benefits ORT-related) and to certain historical reasons (especially, the development of a paradigmatic, ORT-like initiative to study admissions to hospices with outlier lengths of stay in Puerto Rico, just before ORT).

7.2 ORT and the Processes of Policy Change

Operation Restore Trust had an impact on a series of important policy changes, reflecting the greater emphasis being placed on linking enforcement processes to policy processes. Between 1995 and 1997, the major policy changes possibly influenced by ORT were as follows:

- Balanced Budget Act of 1997 — This act contained major anti-fraud provisions, including:
  - tighter controls on providers convicted of felonies or health care-related crimes
  - expanded civil money penalties
  - requirements for increased provider information and for surety bonds by home health agencies and DME suppliers
  - improved information for Medicare beneficiaries
  - replacement of reasonable charge payment methods by fee schedules
  - improved ability of Medicare to pay fees that are no higher than an "inherent reasonableness" standard
  - requirements for competitive bidding demonstrations
  - requirements designed to prevent hospitals from favoring related providers in recommending post-hospital care to patients
  - requirements to pay home health agencies and hospices based on where services are provided, and a restructuring of hospice benefit periods to prevent abuse
  - requirements for skilled nursing facilities to bill Medicare for all services their residents receive
  - extension to non-physician practitioners of the requirement to provide diagnostic codes for items and services provided
  - elimination of interim payments for home health agencies

  Several other measures contained in the act — notably the implementation of prospective payment methods for both nursing facilities and home health agencies — can be expected to discourage fraud and abuse, but were enacted for reasons that went well beyond those expected effects. Medicaid also received a number of new fraud and abuse protections.[50]

50 Some of the Medicaid provisions (such as surety bonds) paralleled the Medicare provisions. Other Medicaid provisions included a ban on spending Medicaid funds on non-health-related items, conflict of interest safeguards for Medicaid administrative contractors, a requirement for tracking payments for dual eligibles, and requirements for states to establish mechanisms to receive reports from beneficiaries and compile data on alleged instances of waste, fraud, and abuse.

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) — This act, known less formally as the Kassebaum-Kennedy Act, became law in 1996. Most provisions of the act were directed at private-sector health insurance markets. But certain key provisions provided major increases in longer-term funding for anti-fraud efforts by DHHS and the Department of Justice. The ORT funding model—and interim ORT results—were of some importance in the passage of these provisions.

- Home health agency standards — Extensive new regulations on conditions that HHAs must meet to participate in the Medicare program were published in March 1997. Most of these regulations were related to quality assurance and the collection of a standard dataset on all patients. One provision, however, would require that a majority of services be provided by HHA employees, a provision designed "as a means of preventing the establishment of 'shell' HHAs that are merely a fax machine and a nurse used as a billing system."[51] More significantly, in September 1997, the President declared a six-month moratorium on certification of new home health agencies for participation in the program. This moratorium is designed to allow HCFA to develop appropriate safeguards to protect the program against abusive providers (see Section 7.1.1 above).

- DME provider standards — As noted earlier (see Section 7.1.2 above), HCFA is taking a number of steps to establish more stringent standards for DME suppliers.

- Care plan oversight — Effective January 1, 1997, Medicare changed the rules for physicians who bill for overseeing the care of beneficiaries who are receiving hospice care or home health care.

- Compounding of medications — In June 1996, the Medicare Carrier's Manual was modified to require that only pharmacies could bill Medicare for drugs used in conjunction with durable medical equipment or prosthetic devices. The change followed a recommendation from the ORT team in Florida and ORT-related studies by OEI in Philadelphia.

- Independent physiological laboratories — In November 1996, HCFA published a regulation in the *Federal Register* to circumscribe the services for which these laboratories could bill. Further restrictions were published in the *Federal Register* in October 1997.

The first difficulty in interpreting these policy changes and others is measuring the impact that Operation Restore Trust had on them. In some cases, the impact is fairly direct: e.g., the DME proposals, which followed from a focused set of studies by OEI in Philadelphia (on drugs/nebulizers) and work by HCFA in Florida (on provider standards). In other cases, many factors are at work, but ORT efforts played a critical role: e.g., the moratorium on certification of new home health agencies, which occurred in a prepared context (widespread dissatisfaction with safeguards on the home health benefit), but was propelled by a major OEI study and a revealing audit by OAS. In yet other cases, the connection is more ambiguous. At any point in time, there are always several changes in Medicare policy under serious consideration, with or without ORT. For example, prospective payment for HHAs has been suggested by diverse groups for several years. Senior DHHS officials assert that the results of Operation Restore Trust helped to create a climate in which anti-fraud efforts had a better chance of success, not only on Capitol

51 Health Care Financing Administration, "Medicare and Medicaid Programs; Conditions of Participation for Home Health Agencies (Proposed Rule)," *Federal Register* 62:46 (March 10, 1997), p. 11016.

Hill but also within the Administration. That is a fair statement of ORT's influence. But more explicit causal relationships are generally difficult to prove. Consider the Balanced Budget Act, which was enacted several months after the end of the demonstration and included measures specifically targeted on the ORT focus areas of durable medical equipment, home health care, and nursing facilities. ORT doubtless had a major role in the passage of the Balanced Budget Act's anti-fraud provisions. However, as we have noted throughout this report, the reason ORT focused on these areas was precisely that these areas were widely thought to harbor unacceptably high levels of fraud and abuse. ORT did not create this awareness, even if ORT enhanced it. Meanwhile, ORT is less likely to have made a substantial contribution to the other major piece of legislation over this period, the Kassebaum-Kennedy Act. This act passed when ORT was only a year old, and the act's provisions were also less targeted to the ORT focus areas than was the case with the Balanced Budget Act.

Quite apart from the issue of causation, there remains the issue of effects. We have not done any independent appraisal of the likely results of these policy measures, for reasons described in Chapter 2. But these policy changes are critical anti-fraud weapons, given ultimate limits on the effectiveness of an anti-fraud strategy based purely on retrospective enforcement (i.e., on "pay and chase"). The scale of possible effects of these policy measures is suggested by recent independent estimates. For example:

- The Congressional Budget Office estimates that the explicit anti-fraud provisions in the Balanced Budget Act would reduce outlays by $300 million between FY 1998 and FY 2002.[52] Not all of this $300 million is ORT-related, however, as this figure includes not only the effects of ORT-related provisions (e.g., surety bonds), but also the effects of provisions unrelated or only tangentially related to ORT (e.g., competitive bidding). And even for those provisions directed squarely at the ORT focus areas, it would be very difficult to attribute credit for any associated savings to ORT alone, given all the other influences present: Department of Justice efforts, Congressional fiscal concerns, widespread press attention, and others.

- CBO also estimated that prospective payment for nursing facility services and home health care would reduce outlays over five years by $9.5 billion and $16.2 billion, respectively. Large though these figures may be, it is difficult to attribute these potential savings to ORT, since reduced incentives for fraud and abuse were only a part of the reason that Congress approved prospective payment for these services.

Thus, the possible effects of ORT may be quite large, but specific attribution of those effects to ORT is difficult to do.

There is a final problem in thinking about the level of savings associated with ORT's effect on policy changes. To do credible estimates of the influence of ORT on savings, we would need somehow to estimate the level of policy change that would have occurred without ORT — i.e., to provide an answer to the question of "what would have happened anyway." No independent estimate of the effects of recent policy changes has attempted to answer this question (that is not surprising, as any such estimate would be enormously difficult to do). But in the absence of such estimates, nominal savings estimates cannot be taken at face value as estimates of the *incremental* effects associated with ORT — even for those policy changes entirely attributable to ORT — since some policy-change activities would have occurred without ORT.

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52 Congressional Budget Office, "Budgetary Implications of the Balanced Budget Act of 1997," (Letter), August 12, 1997, Table 4A. The $300 million reduction refers to all provisions in the subtitle except one unrelated to ORT about advisory opinions regarding self-referral, which CBO estimated would increase outlays by $200 million

In sum, the expected savings from policy changes are difficult rigorously to estimate and to attribute to ORT (or any other single intervention). But these difficulties do not minimize the significance of ORT's role in generating policy changes, the magnitude of the possible effects of those changes, or the more general importance of the changes themselves for making fraud and abuse in the Medicare program more difficult.

7.3 The Office of Evaluation and Inspections

OEI is the smallest of the three OIG components that have regional offices. Under Operation Restore Trust, OEI conducted approximately 40 studies. Most of these OEI studies were little different than they would have been if ORT had not existed. Most of the "ORT studies," in fact, were initiated before ORT began. Of the three OIG components, most people we talked to agreed that ORT had the most effect on customary ways of doing business at the Office of Audit Services, followed by the Office of Investigations, followed by the Office of Evaluation and Inspections.

Nevertheless, there were some important changes in OEI, as discussed below. Most of these changes reflected a central characteristic of Operation Restore Trust*: that resources in several federal agencies in five states were all focused on the same areas at the same time — pointing again to the importance of focused efforts under ORT*. There were three major changes:

- More comprehensive and intensive studies — In certain instances, ORT permitted the development of clusters of work that had a more powerful combined impact than would individual studies:

  — *Home health* — When OEI worked on home health care, for example, it was not alone. OAS, OI, HCFA, and other agencies were also focused in that area. This combination of resources and attention meant that solid bodies of evidence were accumulated over a relatively short period (2-3 years). In home health care in particular, OEI was producing nationwide results that showed inappropriately high utilization at the same time that OAS was conducting in-depth audits on HHAs, OI was pursuing high-profile investigations, and HCFA was drafting new conditions of participation for HHAs. These efforts helped to support major policy initiatives, including the six-month moratorium on certification of new home health agencies, announced by the President in July. The same concentration of complementary initiatives occurred to a lesser extent with skilled nursing care, durable medical equipment, and hospice care.

  — *DME*— A quasi-ORT partner (OEI in Philadelphia, which worked closely with New York on DME) undertook a series of related studies of nebulizers and drugs, finding that the most serious problem with the nebulizers was with the drugs. HCFA did not have evidence. OEI's focused sequence of substantial studies gave HCFA the needed evidence and led to major policy-making initiatives, including a requirement that DME suppliers have a pharmacist for dispensing these drugs (this policy took effect in April 1997), major pricing changes for these drugs (eliminating certain markups, proposed in the President's budget for FY 1998), and major coding changes for the drugs (HCFA is developing a coding cross-walk).

  — *Hospice* — As noted earlier, certain hospice studies were completed showing disturbing patterns of hospice services to nursing home residents.

Thus, ORT encouraged a set of more intensive and comprehensive studies that had important policy impacts.

- Demonstrating a local role as a center of statistics/data to target enforcement — As noted, most OEI studies are national in scope. Under ORT, one region (Dallas) demonstrated an alternative role for OEI, bringing genuine in-house analytic sophistication to database development and the targeting of *local* enforcement efforts, notably through development of a major Medicare-Medicaid nursing home data base.

These were the major effects of ORT on OEI we observed. Based on our interviews, it appears that these changes came about from the collaboration brought about by ORT, the discretionary resources provided by ORT (for such items as computers and travel), more expeditious access to HCFA data,[53] and more cooperation with OAS and OI.

7.4 The Administration on Aging

Under Operation Restore Trust, the federal government experimented with reducing fraud and abuse by educating beneficiaries and the people who work with them about how to identify and report suspicious situations. The "aging network," which includes long-term care ombudsmen and others who have daily contact with senior citizens, was trained through a series of seminars across the five ORT states. Beneficiaries were reached through pamphlets, posters, video tapes, newspaper and newsletter articles and similar means.

Coordinating these training and outreach efforts was the chief contribution to Operation Restore Trust of the Administration on Aging, which was by far the smallest of the three ORT partners. Involvement in anti-fraud work was a new role for AoA and the state and local agencies on aging with which it works. Essentially all of the $0.2 million ORT budget for AoA was devoted to these activities. The total resource cost was probably several times higher, since federal, state, and local officials spent thousands of hours organizing and participating in training sessions and preparing educational materials. Even with a larger budget, however, the network still would have needed considerable assistance to carry out its role because of its lack of experience in Medicare fraud and because many members of the aging network either work or volunteer for state and local organizations. HCFA and OIG assisted by providing speakers and funding some costs of the training efforts. The level of state cooperation varied. The Florida, Illinois, and New York governments seemed to embrace Operation Restore Trust, while California and Texas were more hesitant. Federal officials thought state officials were hesitant due to broader federal-state tensions involving presidential campaign politics (since the 1996 campaign coincided with much of Operation Restore Trust) and concerns about the federal government offloading its responsibilities to states without accompanying funding. (We did not ask California and Texas officials about their views of ORT.)

The impact of the AoA efforts is difficult to measure. Our best estimate of the results is as follows:

- Training — About 4,100 people were trained in 78 sessions. Although the format varied, sessions typically lasted one or two days and featured speakers from OIG, HCFA, and other agencies who described the magnitude of fraud and abuse, gave examples of particular schemes, and encouraged participants to report their suspicions.

53 Now that ORT is over, however, some OEI officials indicated that Medicare claims data is becoming more difficult for them to obtain.

- Referrals — Our survey of AoA regional offices found about 200 referrals attributed to the training efforts. It is impossible, however, to confirm this number from other records[54] or to determine the quality of these referrals and the outcomes they produced.

- Outreach to both the aging network and to beneficiaries — The impact of outreach to beneficiaries is even more difficult to track, although it is clear that beneficiaries in the five states heard more about health care fraud than they had previously.

There is thus some uncertainty about ultimate impacts, although all of these efforts can be viewed as incremental effects of ORT. They have no analogue in pre-ORT activities of the agency.

Using AoA people in the field as an additional set of "eyes and ears" for spotting fraud makes good sense in principle. Moreover, a good argument can be made that fraud and abuse training fit well with the traditional role of the aging network, and of ombudsmen in particular. The members of the aging network were not asked to become investigators or actively to seek out fraud and abuse. Rather, they were given some knowledge about what fraudulent and abusive schemes looked like and advised about what to do when they observed suspicious behavior.

But for this process to work, those making referrals need to know about the impact of what they do. As a rule, according to AoA staff, people who make referrals do not learn of the outcomes, or even whether the referrals were actively investigated. Some imperfection in feedback is inevitable, given the investigators' needs for both secrecy and movement at deliberate speed. But the investigative process does appear to be unnecessarily difficult for AoA staff to access. The frustration of not knowing what, if anything, happened to a complaint may undermine the entire initiative to educate the aging network. "If strong, decisive actions are taken, and this information is communicated to the ombudsmen, I believe we will see a sharp increase in the number of ORT-type complaints," one AoA official told us. "If not, we will see a decrease in the number of complaints submitted by ombudsmen in the future."

Further information on AoA activities appears in Appendix 2.

7.5 HCFA and the Medicare Contractors

We have noted to this point a variety of different ways in which HCFA activities changed under ORT (e.g., expanded annual home health and nursing home surveys with state and other federal staffs, to look beyond issues of formal compliance to possible fraud and abuse; more active policy review and change; and the development of new information resources to enhance detection and enforcement capabilities). In addition, before and during ORT, HCFA was working to make major changes in how its carriers and intermediaries handled the program integrity function. In this section, we will review our findings on carrier activities under ORT, and then summarize our estimate of the effects of these activities.

7.5.1 Medicare Contractors: Earlier Findings

Medicare contractors are a key to fraud and abuse enforcement — they pay Medicare claims, and they enroll most Medicare providers. But Medicare contractors were not formal ORT partners and received only incidental amounts of ORT funding. Contractors performed these ORT activities as part of their

54 CIMS shows only two possible AoA referrals for ORT subject-type cases. However, that figure does not settle the issue, since many AoA referrals would have been for subject types other than ORT types, and AoA referrals did not typically go directly to OI (e.g., most were indirect, through the hotline and other sources).

significant program integrity responsibilities, but without the more explicit obligations and commitments that direct ORT funding would have involved.

In the first part of our evaluation, we interviewed 5 of the 20 contractor operations serving ORT states. In the second half of our evaluation, we made a more intensive review of two contractors, seeking to obtain more discriminating information on contractor policies, staffing, and operations. Both sets of studies are presented in Appendix 3.

Our most important conclusion about the contractors is that their involvements in ORT varied, depending on the contractor and on the activities of the ORT activities for each state. From where contractors sat, ORT was having a beneficial effect on the two groups with whom contractor program integrity staffs most often work: HCFA and the OIG. But realistically, from the contractors' points of view, the big sea change of the past few years is not ORT (in which they had no formal part), but rather the major changes under way in how HCFA contracts for claims processing and program integrity activities (which is central to contractors' Medicare business). Given the prominence of the latter, the former is reinforcing, but not a major event.

In our Interim Report, we noted that contractors played key roles in ORT projects in all ORT regions. These enhanced interactions between contractors and ORT partner agencies were evident in: 1) the training that Regional Home Health Intermediaries (RHHIs), DME Regional Carriers (DMERCs), and other contractors provided to the state surveyors; 2) the use of contractors' medical review nurses in some of these surveys; 3) the provision of contractor speakers for ORT education and outreach sessions; 4) the assistance of DMERC fraud staff, especially in Florida and California, for investigating suspect DME suppliers; and 5) the provision of expert analytical support to all three OIG components and to HCFA in many of the ORT projects across the regions (e.g., doing data runs to identify suspicious providers for further analysis). In addition, it appears that contractors have put more effort into "front-end" efforts to combat fraud and abuse. Specific ORT projects have prompted Medicare contractors to implement more controls in the front-end of the claims process to prevent payment for inappropriate or non-covered services. Evidence of these increased cost avoidance controls can be seen in Illinois (where the RHHI has instituted more rigorous diagnosis screens for hospice patients and initiated new medical review policies) and in California (where the DME regional carrier has revised its medical review policies for three groups of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) to avoid paying for non-covered and/or medically unnecessary products and services). All these contractor actions resulted from their collaboration with the Federal partner agencies on ORT projects.

7.5.2 Detailed Studies of Two Carriers: Transamerica and Blue Cross-Blue Shield of Texas

As noted, our second wave of case studies was more intensive than our first wave. For these more intensive studies, we visited Transamerica Occidental Life Insurance Co. (TOLIC) in southern California and Blue Cross and Blue Shield of Texas (BCBSTX).

The case studies of the two Medicare contractors revealed contrasts in two important dimensions: 1) their organizational structure and personnel skills for the program integrity function, and 2) the number, type, and intensity of their ORT-related activities. We discuss important differences between the contractors on each of these dimensions below.

Organizational and Personnel Differences

The contrasts between the two contractors at the organization level, and particularly in the fraud and abuse area, are quite striking. As part of a general overhaul of its Medicare organization, TOLIC centralized most of its fraud and abuse functions within one operational division in early 1994. TOLIC officials told

us this overhaul was prompted as much by HCFA demands — for improved and more efficient customer services and program integrity operations, for example — as by corporate management priorities. Thus, TOLIC has placed virtually all major program integrity functions that can be centralized (that is, that are not an integral and necessary part of a larger operation, such as beneficiary communications) within its Medicare Audit umbrella. In a sharp departure from the usual carrier administrative structure, TOLIC has also broken off comprehensive medical review (CMR), a sub-function of a much larger pre- and post-payment medical review operation, and placed it in the Audit Umbrella.

In addition to these structural changes, TOLIC also made important changes in both the types and numbers of staff in its program integrity area. Most of these staff changes involved hiring people from outside the company with specific expertise and experience (and often Certified Fraud Examiner, or CFE, credentials) in the healthcare and insurance fraud field. These new hires included a new fraud unit manager with a law degree who formerly worked for the OIG in the Department of Defense (DOD); two new team leaders, one of whom is a CPA and another of whom was an executive with a workers compensation insurance company; and four new fraud analysts, three of whom have law degrees and two of whom were investigators for state or federal agencies.

The degree of professionalism exhibited by the recent additions to TOLIC's program integrity staff is, in our opinion, unprecedented in our twenty-seven years' working with the Medicare contractor community. TOLIC's administrative and personnel structure truly represents the new vision toward which HCFA has been pushing its contractors (sometimes with considerable resistance) since the early 1990s. And no doubt, these organizational and staffing characteristics played an important role in HCFA's recent decision to select TOLIC to be the Medicare Integrity Program (MIP) contractor for the six western states formerly served by Aetna.[55]

BCBSTX, in contrast to TOLIC, and with one important exception discussed below, appears to mirror the old contractor regime in program integrity, both in terms of organization and personnel. Organizationally, it exhibits all the signs of the more fragmented, decentralized approach to program integrity that existed over the first twenty five years of Medicare, and that persists to the present day among many contractors. Here we find a stand-alone fraud unit with no apparent direct management connections to other important program integrity-related functions. Thus, for example, key program safeguard functions, such as comprehensive medical review, the Medicare Fraud Information Specialists (MFIS), and even the statistical analysis area (as embodied in the Data Analysis Team) are located in other operational areas of the corporation's Medicare organization.

In terms of personnel, while all the fraud unit staff we talked to in our site visit appeared experienced and knowledgeable, none exhibited the types of professional credentials (e.g., law and accounting degrees, CFE accreditation, prior investigation experience, etc.) we saw at TOLIC. As noted in Appendix 3, to staff the fraud unit, BCBSTX appears to have relied on the traditional "promote from within" route to retain and advance experienced Medicare staff. Of course, in normal times and most circumstances, this is a practice that most progressive organizations follow to foster good performance and future growth. But it is fair to question whether this practice should be followed today. The message we and others think HCFA has been sending calls for contractors to employ new types of people, many with skills different from those of their predecessors, to more aggressively combat the problem.

The one exception to this traditional staffing pattern at BCBSTX is the Data Analysis Team recently established by the contractor. The composition of this team, especially the statistician/analyst position,

55 This contract was itself a concrete step in the implementation of HCFA's new carrier regime, as it split off the program integrity function from the claims processing function for these states.

is evidence the contractor is responding to a key part of HCFA's message — i.e., to use smarter and more sophisticated methods to identify abuse and target areas for more prudent use of scarce program integrity resources.

ORT-Related Differences

We were quite surprised that the contractors were so different in their degrees of involvement in the ORT demonstration. TOLIC was much more involved than BCBSTX in its region's ORT projects, even to the point of being a quasi-participant. In terms of investigations, TOLIC's program integrity staff worked with HCFA analysts in the Regional Office to investigate psychotherapy services in nursing facilities, and in a host of other projects for both HCFA and the OIG (see our discussion of California ORT projects in Appendix 1). BCBSTX, by contrast, could remember only one specific investigation in which the fraud unit worked directly and actively on an ORT project, that being an OAS study of the relationship of DME suppliers to ordering physicians. Thus, on its face, the unit's participation in this project appears to have been quite limited and certainly not in the nature of the active involvement exhibited by TOLIC. In fairness to BCBSTX, we should note that other areas of its Medicare operation provided assistance to HCFA and the OIG in at least three other ORT projects, and the fraud unit itself opened a number of investigations of ORT-related providers (the Independent Physiological Laboratory (IPL) and body jacket cases being the most notable).

The contrasts between the two contractors surprised us. We expected to find parity among the two contractors, more or less, when it came to the degree and intensity of their ORT-related interactions with the regional offices. It is possible that these differences in involvement may reflect differences between the two regions' approaches to using their contractors in ORT-specific activities, rather than the differences between the two regions' contractors. But whatever the explanation, the differences discussed above highlight an important characteristic of ORT — the diversity in the way it was applied across the five regions, a diversity clearly exhibited in the findings of the second wave of contractor case studies. The patterns were not always simple — an "active" ORT region (like Texas) did not necessarily have "active" contractors on ORT activities.

We are in no position to make a judgment on the overall effectiveness of the program integrity activities of the two contractors. That assessment must be made by HCFA and others with responsibility for oversight of Medicare contractors. But our review of these contractors suggested that HCFA's new carrier regime is taking concrete shape, albeit that the transformation is not entirely uniform across regions.

7.5.3 Analysis of Contractor Case Record Data from HCFA's Fraud Investigation Database (FID)

In addition to the contractor case studies, we proposed in our Evaluation Design Report to exploit the FID database, if that database were available, to give some estimates for the effects of ORT on anti-fraud activities of HCFA and its contractors. Unfortunately, as of July 1997, FID data for 1996 and 1997 were incomplete. (There were also certain other limitations of the FID documented in Appendix 3.) As a result, we were not able to use the database for this purpose in our evaluation. However, our analysis of the FID data did document the following points about contractor fraud and abuse initiatives:

- FID data provide evidence of greater contractor enforcement activity *prior to* ORT, reflecting major HCFA initiatives with contractors before ORT began, particularly the DMERCs and related initiatives.

- Given the limitations of FID -- especially the incomplete data for recent years -- it is too soon to say whether ORT had a notable effect on contractor activity in ORT states and

for ORT subject types. The most we can say is that ORT effects, if any, are not so large as to be detectable in FID as of July 1997.

Thus, at this point, the FID data provide a useful reminder: ORT was not the only anti-fraud activity in the mid-1990s. In the case of the Medicare contractors, HCFA had already begun initiatives that appear to have had important, positive effects, both before and coincident with ORT. When the 1996 and 1997 data are complete years hence, HCFA will be in a better position than we are now to compare the relative effects of ORT and other initiatives on contractor activities.

7.5.4 The Effects of HCFA and Its Contractors on ORT Outcomes

The ultimate effects of the activities of HCFA and its contractors are likely to be positive. However, for reasons noted throughout this section, data are not available to support systematic estimates of how these activities affected ORT savings. In place of such estimates, we will provide a qualitative summary of the effects of ORT activities of HCFA and its contractors. In particular, our anecdotal findings in Appendixes 1 and 3 help suggest the possible magnitude and source of possible savings from HCFA and contractor efforts during ORT. We have no way to know if these are true ORT savings (most importantly, because we do not know the savings that would have occurred in the absence of ORT). Savings from HCFA and contractor projects and other related activities in the ORT regions, as documented in Appendixes 1 and 3, include the following:

California

- Phase I and II of HCFA's home health agency survey project resulted in the termination of 18 of the 44 agencies surveyed. In addition to the estimated $1.7 million in cost avoidance savings which resulted from those terminations (i.e., beneficiaries who do not start up with new agencies when their old agencies are terminated), Blue Cross of California (BCC) identified $0.5 million in overpayments (of which $0.3 million had been collected by the end of September 1996) from on-site medical reviews at four of these agencies. In addition, BCC had 16 of these agencies on focused medical review for 1996, resulting in claims denials in excess of $0.3 million. An additional $8.0 million overpayment is pending as a result of billings from uncertified branches of some of these agencies. BCC also stepped up its cost report audits of some of these agencies and identified cost report adjustments totaling $19.6 million, of which $7.8 million had been recouped by the end of September 1996.

- HCFA performed intense data analysis and collaborated with Transamerica, the Part B carrier for southern California, to develop more rigorous prepayment medical review edits for claimed psychologists' visits. These edits were said to have produced $30.3 million in savings during the two-year ORT demonstration.

Florida

- HCFA Health Standards and Quality staff worked in teams with an OAS auditor and a state survey agency nurse to conduct expanded audits of 20 skilled nursing facilities. Overpayments for the first 16 facilities reviewed totaled $2.5 million.

- HCFA HSQ staff also worked with OAS auditors and intermediary staff on a set of expanded audits of five home health agencies in Florida. Through these audits, $6.6 million in estimated Medicare overpayments were identified.

- A joint effort between HCFA's Miami satellite office and the Part B carrier led the carrier to install what it called its "medically unbelievable" screen for claims exceeding pre-specified line-item counts per patient over a certain time period. By the end of the ORT demonstration, the carrier had denied $31.9 million in claims from the screen, with net savings of $31.4 million after $0.5 million in reversals from appeals are taken into account.

Illinois

- As a result of HCFA's expanded surveys of home health agencies under ORT, the intermediary had identified almost $0.8 million in overpayments, of which $0.3 million had been recovered by the end of ORT. In addition, through April 1997, the intermediary had denied $0.2 million in claims from prepayment edits developed and installed as a result of the survey project.

- HCFA's expanded surveys of hospice providers resulted in the intermediary calculating $0.1 million in overpayments from two providers (of which no funds had been recovered by the end of ORT). The project also led the intermediary to implement global edits on selected types of hospice claims. These edits should produce additional savings in the post-ORT period.

New York

- A HCFA reimbursement specialist performed some initial research in response to a routine query about portable x-ray services and discovered an abuse of these services for patients in nursing homes. To date, the New York Part B carriers have instituted actions to recoup $5.3 million in overpayments from selected providers (of which $0.5 million had been recovered by July 1997).

- HCFA staff performed an analysis of claims from physicians for overseeing the care plans of home health and hospice beneficiaries and found that many care plan services were inappropriately billed to Medicare. By July 1997, recoveries from over 400 physicians had exceeded $0.4 million. HCFA is replicating this study on a nationwide basis and says the potential overpayment may exceed $30 million.

Texas

- A total of $9.1 million in overpayments had been identified as of June 1997 through all three phases of HCFA's home health agency survey project, of which approximately $4.0 million had been recovered by the regional home health intermediary.

- HCFA's review of Part B payments for DME to nursing home patients led the DMERC to calculate a total overpayment of $2 million from about 500 suppliers in the state. As of May 1997, the DMERC had recovered almost $1.8 million, or close to 90 percent, of these overpayments.

This overview of examples suggests that the impact of efforts of HCFA and its contractors may have been quite large, although a true savings estimate will have to await better data.

7.6 The FBI and the Department of Justice

As noted earlier, both the FBI and DOJ were devoting more effort to combat health care fraud, as ORT began. This section will briefly review how these changes affected collaboration of the FBI and DOJ with DHHS (see Appendix 4 for further details).

7.6.1 The Federal Bureau of Investigation

During ORT, the FBI and OI each posted an agent in the other organization's central office as a way of improving coordination. And in each of the ORT states, FBI agents told us that collaboration with the Office of Investigations increased in recent years. But the role of Operation Restore Trust appears to have been tangential at best. One agent said there has been "absolutely no impact whatsoever from Operation Restore Trust." While less adamant, other agents ascribed the increased collaboration to a mix of factors such as new OI personalities in a couple of states, increased staffing in both the FBI and OI offices (and therefore more people to collaborate with), a growing realization that there was "enough fraud for everyone," and a growing appreciation of the benefits of cooperation. "But I'd be hard pressed to say it's because of ORT," another senior FBI official said. To the extent that ORT did make a difference, the difference appears to have been simply the increase in OI agents that it allowed. "The commitment with hiring people has allowed them to do much more," one FBI agent commented.

There also was more collaboration between the FBI and the Division of Medicare, but the increases have been modest. To be sure, Medicare has sponsored training sessions for FBI agents, and these sessions are reported to have been very useful. Asked whether HCFA would have conducted such sessions several years ago, one FBI agent responded, "Absolutely not." In California, the Division of Medicare actually worked on some cases with the FBI, which was unprecedented. Thanks to a protocol signed between DHHS and DOJ, FBI agents now have easier access to Medicare contractors and contractor data. But the agents also said they would be more effective if they had increased access to Medicare data and to the expertise of the Office of Audit Services, which has been involved in very few FBI investigations.

One agent even said Operation Restore Trust has not affected HCFA attitudes. "A lot of times people from HCFA don't think there's a fraud here—they think there's a 'lack of education,'" was this agent's comment. "It's very difficult to deal with the higher-ups at HCFA, who haven't recognized that the world has changed." Based on the interviews we conducted with DOJ and DHHS officials, the agent probably held a minority opinion. But this opinion illustrates the gaps that still exist between law enforcement personnel and program officials.

7.6.2 The Department of Justice

Just as the FBI has sharply increased its efforts on health care fraud, so too have the U.S. Attorney's Offices across the country. For example, the number of criminal prosecutions for health care fraud tripled between FY 1992 and FY 1996, from 83 cases nationwide to 246. There was a similar increase in civil suits filed, from 28 in FY 1992 to 90 in FY 1996.

Separately, there has been a sharp increase in the number of *qui tam* (or "whistleblower" suits) that have involved allegations of health care fraud under the False Claims Act. Amendments to the law in 1986 made it more attractive for individuals to file *qui tam* suits. In these suits, an individual alleges that a firm (often the individual's employer) defrauded the government. The government can choose to join or not to join the suit. In either case, the individual receives a share of any recoveries. In 1992, 119 *qui tam* suits were filed across the country, of which 14 alleged health care fraud. By 1996 the number of suits had jumped to 361, of which 200 involved health care. Since 1986, the federal government has recovered about $1.3 billion from *qui tam* cases, of which about one-quarter came from health care cases.

In addition to the sharp increases in staffing, the U.S. Attorney's Offices also undertook or participated in several other initiatives designed to increase the resources devoted to health care fraud and to ensure that those resources were better coordinated. Since 1993, for example, each of the 94 U.S. Attorney's Offices has designated a coordinator for health care cases. Larger offices have separate coordinators for criminal and civil actions. The coordinators typically have other responsibilities, however. At DOJ's central office, a Special Counsel for Health Care Fraud was appointed to coordinate initiatives within the Department and with other departments. As of July 1997, this position was vacant, however.

As was true with the FBI, these changes were substantial, important, and probably not due to ORT. "It can't all be attributed to ORT... it seemed to all happen at the same time," was how one attorney put it. These changes, like ORT itself, were an indication of the deepening concern in Washington about health care fraud.

At the working level, the DOJ attorneys with whom we spoke reported little change in the types of cases they were receiving from the Office of Investigations, although the numbers had increased. But several did refer to new attitudes at HCFA. "The change at HCFA is huge," one said. " HCFA has become extremely conscious and extremely concerned about fraud and abuse prevention and enforcement, and has become a very active partner with us." In Miami, an assistant attorney described the new HCFA satellite office in that city as "an immense help." During ORT, the USAO, and the Division of Medicare established a working relationship where previously assistant attorneys had to try to find help on policy questions from the HCFA central office in Baltimore. "We'd get the 'ivory tower read,' and now we don't have to deal with that any more," one said.

Chapter 8
Findings of the Evaluation 5: Hotline, Voluntary Disclosure Program (VDP), and Special Fraud Alerts (SFAs)

In addition to the region-specific efforts that were the heart of ORT, the demonstration included three projects that were associated with the ORT initiative but were national rather than regional in scope: the hotline, the Voluntary Disclosure Program (VDP), and special fraud alerts (SFAs). These three initiatives were envisioned as key support capabilities/policies, as part of a more general improvement in detection and investigation. In the end, the results were mixed or disappointing for all three initiatives. Appendix 10 explains why, in detail. We summarize those results here.

8.1 The Hotline

The OIG hotline, in place since 1979, was substantially expanded under ORT. It was one of the largest direct ORT expenditures, with costs over the two-year demonstration totaling $0.9 million, or 11% of the ORT budget. In the later months of Operation Restore Trust, the hotline was handling about 1,500 phone calls and letters a month, though only about 500 were complaints alleging fraud or abuse and only 60 of those involved the ORT focus areas in the ORT states.

The hotline was not actively advertised nationally. Due to somewhat more intensive publicity in the ORT states (along with certain hotline procedures giving special handling to ORT-related issues), 61% of hotline complaints came from the five ORT states, which together account for only one-third of Medicare beneficiaries.

From June 1995 to March 1997, almost 14,000 actual complaints were received. Of these complaints, 63% involved Medicare Part B programs, 22% involved Medicare Part A programs, 9% involved Medicaid programs, and 7% involved the Public Health Service, other health programs, or Health and Human Services staff. By March 31, 1997, 566 complaints had been resolved with monetary recoveries, 2,980 had been resolved without a monetary recovery, and 10,248 had not yet been resolved. According to hotline staff, total recoveries[56] were $6.1 million, essentially all of which represented recoveries made administratively by Medicare carriers and intermediaries (carriers and intermediaries confirm these recoveries in letters sent to the hotline). This figure is likely an underestimate of the recoveries that will accrue in total from the ORT-period complaints.

With $6.1 million in recoveries and almost $1.0 million in direct costs, the hotline likely passes any rudimentary test of costs versus benefits. However, the usefulness of the hotline as an *investigative tool* is less clear. In our interviews with investigators, auditors, and Medicare officials at the regional level, we usually heard that the hotline generated paperwork but not fresh and useful information. Meanwhile, our analysis of CIMS shows the hotline was the source of just 13 ORT-subject-type cases for OI over the two years of ORT, and none of these cases had resulted in savings, sanctions, a criminal prosecution, or a civil lawsuit by the end of our data series (March 1997). It is fair to say that the role of the hotline in Operation Restore Trust has been less than expected. Several factors appear to explain this result.

- All complaints are forwarded regardless of merit — Although the hotline staff disregarded calls and letters that were obviously incoherent, they had no choice but to

[56] "Recoveries" in this instance can refer either to accounts receivable or to funds actually received

forward all other complaints either to HCFA central office or directly to the ORT states. Much effort appears to have gone into tracking the progress of complaints that probably had little value in reducing fraud and abuse. Exercising more discretion earlier in the complaint-handling process would help to reduce the amount of work on the hotline complaints without noticeably reducing their overall usefulness. Whether this discretion should be exercised by the hotline, HCFA central office, or the receiving official at the regional level is unclear.

- Beneficiary confusion — Medicaid and Medicare are complicated programs that beneficiaries cannot be expected fully to understand. For example, a beneficiary may suspect fraud when he receives a bill from a physician he never saw, but the explanation may simply be that the bill came from a radiologist who interpreted an x-ray. These sorts of honest misunderstandings take time to investigate and are unlikely to be as fruitful in uncovering suspicious behavior as some alternative approaches (e.g., computerized analysis of aberrant claims).

- Not all results from the hotline may be credited to it — A hotline complaint sent to a Medicare contractor may then form the basis for a referral from the contractor's fraud unit to OI or the FBI. The OI agent is supposed to refer to the hotline in entering the case into CIMS, but this may or may not occur. Moreover, the results of referrals to the FBI or other law enforcement agencies would not be captured in any hotline data.

Thus, while the hotline has been a source of leads for Medicare contractors to use in identifying suspect claims, it has generally not been a visibly effective investigative tool.

It is probably true that any sensible fraud and abuse enforcement process will include something like a hotline. The presence of a single authoritative phone number for any beneficiary to call helps to guide beneficiaries and to preserve notions of beneficiary responsibility for the integrity of the benefit. The OIG hotline was an improvement and modernization of the pre-ORT hotline. But it was not the powerful investigative support that many originally envisioned.

8.2 Voluntary Disclosure Program

As part of Operation Restore Trust, OIG and DOJ introduced a Voluntary Disclosure Program patterned after a similar initiative at the Department of Defense. Under the program, corporate providers were encouraged to report wrongdoing voluntarily, in the hope of receiving more lenient treatment than if the government discovered the wrongdoing on its own. DHHS officials had been contemplating a voluntary disclosure program before ORT — ORT was a convenient vehicle to launch it on a pilot basis.

No particular efforts were made to publicize the program, although it was included in descriptions of Operation Restore Trust. While it is likely that many providers never heard of the Voluntary Disclosure Program, the health care lawyers who advise them are almost certainly familiar with it. A lack of publicity is not likely to be the core problem with VDP.

Providers who entered the program had to agree to cooperate fully with the government. Such cooperation specifically included making documents and employees available without subpoenas, estimating the financial impact of the fraudulent actions on Medicare and Medicaid, helping the government verify that estimate, agreeing to waivers of the statute of limitations, and putting in place a compliance program that included, among other provisions, annual discussions with every employee about business ethics. The OIG tried to have all providers agree to the same terms, and it discouraged attempts to negotiate the

language of the agreement. Under the agreements, providers put themselves at the mercy of the government. While providers might expect more lenient treatment in return for coming forward, the agreements contain no guarantees.

During the 24 months of Operation Restore Trust, 50 to 75 potential applicants inquired about the VDP. In most cases, the call came from an attorney representing a provider. Ten formal applications were received. The government accepted seven applications. Three applications were rejected, in each case because the provider was already under investigation. As of June 1997, funds had been recovered from only one provider. Ironically, this provider was in bankruptcy proceedings, but from those proceedings Medicare received $0.5 million and a Medicaid program received $0.9 million that otherwise would not likely have been received. The amounts to be recovered from the other six participants remain to be seen.

The program has been a disappointment, according to essentially all observers. Several reasons have been suggested for the program's disappointing performance, including :

- Uniqueness of health care fraud — Unlike fraud in the Defense Department, health care fraud may involve payers outside Medicare that are not included in VDP, such as CHAMPUS or the VA.

- Some providers did not like the terms — Some providers did not like the government's insistence on damages, even when (the providers claimed) they only committed "honest mistakes."

- Providers may not have "heard footsteps" — Providers may believe that the probabilities of getting caught are so low that the potential for possible lenience in the unlikely event of getting caught may not constitute much of an inducement.

- The threat of qui tam suits remained — Even with a VDP agreement, providers were still vulnerable to *qui tam*, or "whistleblower," suits.

VDP met a narrow test of costs versus benefits — the state and federal settlements with the first provider exceeded the minimal expense of the programs. But the failures of VDP are in other terms. It was offered as a significant policy initiative that would play a useful supporting role in the new, ORT-style enforcement arsenal (indeed, VDP was one of the five ORT objectives). But in the end, its effects on policy and its role in support of the broader enforcement effort were minimal. Officials in these agencies have limited opportunities to initiate such changes, and there is little evidence that VDP to date has rewarded their efforts. A task force of officials is now reviewing possible improvements to the program.

8.3 Special Fraud Alerts

Under ORT, the Office of the Inspector General was expected to step up its production of "special fraud alerts" and to distribute the alerts more widely. Special fraud alerts have been produced occasionally since 1988. They are "special" in that they are distributed to the public (unlike the fraud alerts that OIG has distributed within DHHS since the OIG was established in 1976).

In the six-year period before ORT began, OI produced five special alerts, less than one per year. In the two years of ORT, another four have been produced, or roughly two per year. The format of the special alerts has not changed under ORT, although there was some effort under ORT to broaden the distribution. Special alerts have long been sent to every Medicare provider and (since 1994) have been reprinted in the

Federal Register. Under ORT, more effort was made to distribute the special alerts to the trade press, to the nation-wide network of state nursing home ombudsmen, and to the general media.

Special fraud alerts are intended to notify abusive providers that their activities are being monitored and to encourage other parties to report suspicious activities. Our brief examination showed the ORT-era SFAs to have had no obvious impact: e.g., there was no obvious relationship between the issuance of a special fraud alert and the volume of hotline complaints received (see Appendix 10).

Like the hotline, SFAs of some kind are a sensible part of any health benefits program. But it is fair to say that SFAs under ORT were a minor presence in the demonstration.

Chapter 9
Comparing the Costs and Savings of the ORT Demonstration

In the preceding chapters, we have discussed various costs and benefits of ORT. As we reach the end of our evaluation, the obvious question to ask is how these various costs and benefits compare. On balance, were the costs of ORT greater than the benefits? Which costs and which benefits?

9.1 What We Do and Do Not Estimate

We have defined ORT "savings" to be the *incremental* effects of ORT on the cash collections and avoided costs of the government — i.e., the dollar returns plausibly linked to ORT over and above what would have accrued anyway, without ORT. While this definition is simple, it places substantial demands on the information available to the evaluation. In particular, it is difficult to measure the savings of ORT, for a set of reasons that we have noted before:

- Difficulties of attribution. The ORT demonstration is so elaborately confounded that it is risky to infer that ORT caused the measured effects we find *associated with* ORT. For example, the sentinel effects we observe are almost surely the result of many public initiatives pushing in more or less the same direction as ORT.

- Difficulties of estimation. Our evaluation cannot estimate all of the effects we would like to estimate, for three key reasons:

  — the data do not exist (e.g., with respect to HCFA and contractor activities, there are no adequate pre-post data for demonstration or comparison areas, as would be needed to support double-difference estimates of the savings associated with HCFA/contractor activities in ORT; and there are no data available to support empirical estimates of the likely collections from ORT-related receivables);

  — the effects are too small, given all the other disturbances in the system;

  — the behaviors that must be estimated are too complex to be estimated indirectly (e.g., in making estimates of deterrent effects, we are forced to rely on indirect (claims) data, and there is too much noise surrounding such indirect measures to detect all of the new areas into which providers might have shifted fraudulent behavior).

- Difficulties of timing. At present, only speculative estimates can be prepared for many ORT effects, because they have not yet occurred (e.g., the results of *most* cases and audits have yet to accrue) or cannot yet be reported (e.g., for a large number of notably effective audits that have been suspended, we have no audit-level record of actual disallowances, because these audits are part of pending criminal investigations).

While these problems exist to some degree in any evaluation, ORT creates them in a particularly vexing form. As a result, we have attempted to measure only the more direct, quantifiable, and timely savings.

Quantitative estimates of savings were developed in three areas, in two of which we faced major difficulties. Our savings estimates for OI cases are the most comprehensive of the evaluation. Our estimates of the incremental effects of ORT on the yield from OAS audits, in contrast, suffer from serious

data and timing limitations. This was the area of the evaluation that was most constrained by the scheduling of the final report so close to the end of the demonstration. Likewise, our analysis of sentinel effects of ORT, while powerful and important, cannot cover the full canvas of possible effects, nor can we claim to have pursued all of the ways providers might act to offset the effects we do estimate.

In three other areas, we do not have any quantitative estimates:

- Changes in policy and operations generally, including the work of HCFA, OEI, OAS, OI, and others: If Medicare is to reduce its reliance on the "pay-and-chase" enforcement philosophy, aggressive changes in policy and operations will be required. We have performed process analyses of these issues (see Appendixes 1-2), but we have not developed independent measures of their effects.

- The effects of ORT on savings from HCFA efforts: There is no centralized dataset that permits us to track the pre- and post-ORT efforts of the 20 HCFA contractor operations that serve the ORT states with regard to disallowances, recoupments, exclusions, and other actions. This situation has prompted HCFA to move, in parallel with ORT, to establish the Fraud Investigation Database (FID), which will permit better tracking of contractor efforts in the future.

- Initiatives — such as collaboration — which primarily affect intermediate outcomes: The effects of collaboration, outreach, and training on savings are indirect, and the independent effects of such initiatives are impractical to estimate. We pick up the effects of these initiatives only through their effects on cases and audits.

We thus take reasonable account of the most important ORT effects, insofar as that can be done at present. But it is too soon for a comprehensive estimate of ORT savings from all important sources, and thus too soon to develop a comprehensive cost-benefit analysis for the ORT effort.

Instead, in this chapter, we will review what can be said about savings and costs, based on data available to us immediately after the end of ORT in March 1997. Exhibit 34 below summarizes our understanding — it sets forth what we believe can be stated at present about the relationship of costs and benefits in ORT.

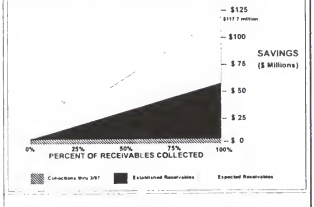
9.2 Costs

In Chapter 3 above, we reviewed the costs of ORT. We believe the minimum "cost of ORT" for purposes of comparison to the savings of ORT is $9.9 million (i.e., the total direct costs of the demonstration, including as a direct cost the added staff devoted almost entirely to ORT projects but funded outside the ORT budget). Our highest cost estimate is $18.9 million, a figure which includes documented and undocumented indirect costs (i.e., costs that are not part of any identifiable ORT budget, but associated in varying degrees with the demonstration).

Exhibit 34. Evaluation of ORT: Summary of Costs and Potential Savings

TYPE OF COST	AMOUNT
DIRECT COSTS	
– Activities funded out of the Medicare Trust Fund (excluding evaluation)	$6.9 million
– 29 additional OIG staff, largely OI investigators, devoted to ORT	$3.0 million
Subtotal	$9.9 million
INDIRECT COSTS	
– OAS staff devoted to ORT audits	$5.5 million
– Cost of other HCFA, OIG, and AoA staff	$3.5 million
Subtotal	$9.0 million
ORT COSTS =	**$9.9 - $18.9 MILLION**

TYPE OF SAVINGS	AMOUNT
DIRECT CASE SAVINGS from incremental effects of ORT on investigations	Some fraction of $117.7 million in addtional receivables associated with ORT cases
– Recoveries ($4.6 million by end of ORT)	
PLUS	
– Future collections from $113.1 million in established + expected future receivables (collection rate unknown)	
OTHER DIRECT SAVINGS that cannot be estimated as of July 1997 (e.g., no data yet)	
– HCFA and contractor activities	? million
– OAS audits	? million
Subtotal	? milllion
INDIRECT SAVINGS that are difficult or impossible to estimate (e.g., data not adequate)	
– Policy changes	? milllion
– Possible sentinel ("deterrent") effects	? milllion
Subtotal	? million
ORT SAVINGS =	**? MILLION**



SOURCE: Abt Associates Evaluation of Operation Restore Trust: Final Report (1997); based on data thru March 1997 (for costs and collections) and May 1997 (for receivables)

9.3 Direct Savings: OI Cases

Through cases, ORT has had a substantial effect on receivables, but not yet on savings. The reason: most cases have not yet matured to the point of collections.

As summarized in Chapter 4, our best estimate is that ORT will result in an increase in receivables of $117.7 million, over and above what would have been generated without ORT. This figure includes $4.6 million already collected. Historical data are lacking on the rate at which receivables translate into actual dollar recoveries. It is accordingly difficult to know at present how to estimate the ultimate impact of ORT on recoveries. What we can say is that some fraction of the $117.7 million in receivables will become direct cash savings.

It is therefore also true that some part of the $117.7 million in receivables will not become direct cash savings. But these uncollectable cases should not be dismissed. It is worth thinking about what it means *not* to collect on a case receivable — that is, to think about other, indirect effects of uncollectable cases. At least some of these cases are among the most important cases that OI develops, since the reasons collections are not possible (e.g., provider bankruptcies) eliminate unscrupulous providers from the Medicare program. In any event, providers who are convicted or reach settlements will face varying levels of suspension or exclusion from the program, depending on the character of their infractions and the ultimate disposition of their cases. To some degree at least,[57] these suspensions, exclusions, and bankruptcies represent providers who will not be submitting claims in the future. These cases thus represent indirect future savings to the Medicare program. Our evaluation takes no account of these future savings, except as their earliest manifestations are incidentally reflected in the sentinel estimates we have made (see Chapter 6). But the temporary or permanent elimination of unscrupulous providers is an important benefit to the Medicare program, even if there is no cash collection associated with the case.

9.4 Other Direct Savings: HCFA and Contractor Activities

The evaluation of HCFA and contractor activity presented a special problem in our evaluation. The conceptual problem was straightforward: we cannot simply add a specific instance of a contractor savings (e.g., from a regional initiative, as discussed in the case studies in Appendixes 1 and 3) to our estimates of ORT savings. Our estimates of ORT savings are pre/post, demonstration/comparison estimates that adjust post-ORT results for results that would likely have occurred anyway, without ORT. This adjustment is especially important for activities of HCFA contractors, since savings activities of the contractors began to increase substantially in intensity before ORT, in apparent response to earlier HCFA initiatives (see Appendix 3). In other words, *pre-ORT* initiatives by HCFA are responsible for some of the change in contractor activity, and we need to be careful in sorting out what is ORT and what is not.

FID data are a potential source for analyzing these activities. Unfortunately, as we discuss in Appendix 3, FID data do not permit us to perform systematic pre/post or demonstration/comparison adjustments, because cases are not entered in FID when the first relevant complaints or referrals are received and investigative activity begins. Instead, cases are entered after some development and verification. This means that FID volume data for a calendar period are not "closed" after the end of that calendar period (cases may be added months or years later), which introduces a significant downward bias for data governing recent — i.e., for our purposes, ORT — years.

57 It is possible for bankrupt providers who have been successfully investigated by OI to resume business in various fraudulent ways (e.g., through provider numbers obtained by family members). These new businesses may go undetected by DHHS, thereby mitigating the positive effects of the nominal elimination of an unscrupulous provider. DHHS is taking active steps to reduce the possibility of this subterfuge.

For these reasons, we do not convert isolated examples of post-ORT recoupments/suspensions/etc. (e.g., as set forth in the case studies) into estimates of "savings." What we do try to present instead is a set of qualitative findings on HCFA activity and contractor activity. Appendix 1 details HCFA's participation in regional activities. Appendix 3 describes the qualitative effects of ORT on contractors and the possible conclusions that can be drawn from the FID data we have. Chapter 7 above provides a summary of these findings.

Overall, these findings suggest that HCFA and its contractors had a series of successful projects under ORT, with notably large collections or documented avoidances of payment accompanying many of these efforts. We cannot say with confidence that these are true ORT savings, since we cannot be sure that these savings or some other savings of comparable magnitude would not have been realized if the ORT demonstration had not taken place. Thus, on Exhibit 34 above, we show only a question mark for HCFA and contractor savings. But that is a limitation due to the character of available data. It says nothing about the intrinsic quality of HCFA and contractor efforts themselves.

9.5 Other Direct Savings: OAS Audits

As indicated in Chapter 5 above, there are some peculiar difficulties in estimating the incremental effects of audits, given the large number of suspended audits. For these audits, which were almost entirely ORT-type/ORT-state audits, there were $81.0 million in questioned costs by the end of ORT. These are among the most productive of OAS audits and must be considered in any savings estimate. But we do not have any information on suspended audits in the pre-ORT period or for comparison states in both periods, as would permit us to develop a reasonable estimate of effects. Furthermore, any estimate of questioned costs must be discounted in some fashion to obtain an estimate of actual dollar recoveries, as we did with receivables.

Different considerations apply to the audits that have not been suspended. Final disallowances on these audits total $21.6 million according to our estimates. But there were too few audits in this category to perform double-difference estimates, as of the cutoff date for our AIMS data (April 1997).

At this stage, we cannot assert even a range for total audit savings. The possible magnitude of savings is quite large, *perhaps on the order of tens of millions of dollars*, given the potential effects of the suspended and non-suspended audits. But there is no way to develop an estimate with any precision or confidence until the suspended audits move forward. Thus, on Exhibit 34, we show only a question mark for audit savings.

9.6 Indirect Savings: Policy Changes

Operation Restore Trust helped to promote a series of important policy changes in the Medicare program. These policy changes doubtless will yield savings of some kind (e.g., see the examples discussed in Chapter 7 above). But the fact that these policy changes may have such effects does not mean that those effects are *ORT savings*. There are two principal difficulties:

- Attribution of savings to ORT — In most cases, Operation Restore Trust is one of many factors contributing to the policy change. When substantial, non-ORT contributing factors are present (i.e., when the policy change is a joint product of ORT and other initiatives), there is no defensible way to attribute any of the estimated savings to ORT *alone*.

- Some of the savings would have occurred anyway, without ORT — Even where ORT's causal role is relatively clear and attribution is not difficult, an equally difficult question must be answered before the *policy-change savings* can be translated into *net ORT savings*. Specifically, we must determine to what extent such savings would have occurred anyway, even if ORT did not exist. The problem here is that policy-making efforts that took place under the aegis of ORT might have occurred without ORT. *Even if ORT alone is plausibly responsible for a particular policy change*, the efforts and resources consumed may have displaced some non-ORT efforts or efforts that would have been undertaken without the encouragement of ORT. As a result, we must somehow subtract what would have happened anyway, without ORT, from our estimates of the policy savings apparently attributable to ORT. While the logic here is fairly straightforward, it is extremely difficult to implement in analyzing policy changes, since we are not even close to having the necessary data (essentially, data to track the effects of all policy changes pre- and post-ORT, in order to isolate ORT policy effects).

In view of these difficulties, efforts to estimate a particular dollar amount of ORT savings from ORT effects on policy processes are likely to be unsatisfactory. That judgment does not mean that ORT cannot have had such effects, only that any such effects are extremely difficult to estimate. As a result, on Exhibit 34, we show a question mark for indirect savings from policy changes.

9.7 Comparison of Costs to Savings: Sentinel Effects

As discussed in Chapter 6, the sentinel effects of ORT (in the selected areas we examined) could be quite large — or they could be zero. If we maintain a standard, double-difference (pre-post/demonstration-comparison) model and conventional levels of statistical significance, our analyses cannot reject the hypothesis that ORT had no sentinel effects, although we do consistently find negative effects for home health agencies and DME outside nursing homes. The fact that they are consistently negative, across ORT states and across the broad range of outcome measures that we examined, suggests that something important was going on, even if there is too much statistical noise for us to pick it up. But if we relax certain assumptions of the double-difference model — i.e., if we do not confine our estimates to the ORT states and if we measure the effects of the full panoply of government and contractor initiatives, not just ORT — we get statistically significant negative effects on the order of 4% - 5% for DME and 13% for home health. The results for skilled nursing facilities remain insignificant.

We conclude that there is an apparent sentinel effect coincident with ORT and other initiatives, although we cannot be sure that ORT alone is responsible. Given deterrent effects of a few percentage points, for types of service in which the expenditures are in some cases measured in the many billions of dollars, *it is obvious that the gross reduction in payments (before accounting for any offsetting provider behavior) could be quite large — larger than any other single component of savings we have estimated for ORT.*[58]

The more difficult question is whether providers deterred in one geographic area (or in one line of business, or with one set of beneficiaries) simply shift their efforts elsewhere, thereby offsetting the savings observed in the first area. We cannot prove that these shifts have not occurred, except by using such "wide screen" measures that we lose our ability to detect any deterrent effects. As a result, on Exhibit 34 above, we show only a question mark for sentinel savings.

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58 For example, benefit payments for Medicare home health services totaled $12.3 billion in Fiscal Year 1994. U.S. Department of Health and Human Services, Health Care Financing Administration, 1996 Data Compendium (Baltimore, MD: March, 1996). A 1% reduction in this large amount would total over $100 million.

While the idea of computing a discrete figure for deterrence savings is attractive, it is perhaps best to view our deterrence findings in summary terms. Our most important findings are that there is some evidence of first-order sentinel effects even in highly aggregated measures, and the possible deterrence effects we find are correlated somewhat with the intensity of ORT efforts.

Meanwhile, it is perhaps worth recalling one of the key underlying difficulties that gives rise to the contingent character of our estimates of deterrence and our hesitation to calculate a savings figure. In our deterrence analyses, our observation of fraud and abuse is indirect, so we must infer deterrence from changes in indirect measures. But that problem does not have to continue. Under the Government Management Reform Act (GMRA) of 1994, OAS has completed a major audit of Medicare claims to provide an estimate of the underlying rates of improper payments (improper payments include fraud and abuse, but also insufficient documentation and other problems).[59] GMRA requires this audit to be performed annually. The availability of annual estimates of improper payments will make it easier to determine underlying trends in fraud and abuse and to establish more definitive estimates of sentinel savings, as such data will permit more confident inferences as to whether or not enforcement has merely displaced where the crime or abuse occurs.

9.8 Comparison of ORT Costs to ORT Savings: Conclusion

Our discussion of costs and savings has necessarily focused on what we do not know or cannot know as yet. But we should not overemphasize the limitations of our estimates. Beneath all of the qualifications above is a story of substantial success. At a minimum, we can say that, at any collections rate over 12%, savings from *OI cases alone* are likely to cover even our most comprehensive estimate of ORT costs ($18.9 million).[60] Indeed, at any substantial collections rate, the savings from OI cases alone will cover ORT costs many times over.

Meanwhile, the savings from other sources are also likely to be substantial: i.e., from OAS audits, HCFA and contractor activities, policy changes, and sentinel effects. The fact that we are unable to estimate savings from all of these activities does not mean that we expect zero savings in each case. Indeed, the results are likely to be positive in each case and are potentially quite large.

In the future when better data are available, it may be useful to develop a more exact estimate of the ratio of ORT benefits to ORT costs. But data available now already give an answer to a key analytic and policy question, concerning the overall relationship of costs and savings in the ORT demonstration. Even using fairly conservative assumptions — and even at this early date in the maturing of cases, audits, and other key activities that will actually produce the savings — we can conclude that the savings from ORT are likely substantially to exceed the costs.

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59 DHHS/OIG, "Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996" (A-17-95-00096, July 1997).

60 Collections at the end of ORT attributable to incremental ORT activity were $4.6 million. A collection rate of just over 12% on the remaining $113.1 million in established or expected incremental receivables attributable to ORT would bring collections to a total of over $18.9 million, our highest estimate of ORT costs.

Chapter 10
Implications and Future Prospects

ORT was an effort to establish a model of purposeful, inter-agency enforcement, to replace the rigorously sequential, uncollaborative processes of the past. In that effort, DHHS brought more resources to fraud enforcement, reversing trends of the preceding few years. But it also focused its resources — and its attention. DHHS developed a targeted set of initiatives designed to take on a few states, a few areas of the Medicare benefit, and a few of the more frustrating standard operating procedures. By being careful in what it took on — and pursuing intensely those few things — DHHS avoided dissipating its efforts and resources.

We conclude that DHHS chose wisely. ORT can fairly be said to have turned around the troubling trends of the early 1990s and — in step with other efforts by the OIG, HCFA, the Department of Justice, and others — to have brought new vigor to government efforts to combat health care fraud and abuse. We have concluded a two-year evaluation of ORT. Our results show that ORT had important effects across the full spectrum of organizations it sought to affect — and even had some important effects on organizations over the boundaries of the demonstration (e.g., Medicare contractors) that were not so directly orchestrated by the ORT initiative. Specifically, we find:

1. ORT was associated with a net increase of over 100% in ORT-type cases investigated by the OI. The increase in cases was particularly large for home health and DME, much smaller for nursing homes. Case initiation became more collaborative, there is some evidence that cases were of higher quality, and there is also evidence of more active agent follow-up to cases. There meanwhile was little evidence of a diversion of investigative resources from non-ORT targets, a result that suggests the wisdom of adding substantially to OI staff at the outset of ORT.

2. These ORT cases should generate substantial *incremental* receivables totaling $117.7 million. Some fraction of those receivables will translate into true savings, as collections are made. Incremental collections as of May 1997 are estimated at $4.6 million, but we expect ultimate recoveries to be much larger.

3. The ORT effect on audits conducted by OAS has been similarly substantial. For example, the volume of ORT-type audits increased over 1000% (on an annual basis) for all ORT subject types, compared to the 1990 - 1994 period. It is difficult to estimate the savings from these audits, since the needed data will not be available until certain audits have moved forward in the judicial process. But we have no reason to believe these savings will not be substantial. Meanwhile, there is ample evidence that ORT resources were especially important to OAS, and that ORT represented a substantial innovation in approach for OAS (more provider-specific, more data-driven audits, at a more significant geographic reach).

4. HCFA and its contractors had a series of successful projects under ORT, with notably large collections or avoidances of payment accompanying many of these efforts. We cannot say with confidence that these are in each case true ORT savings, since (due to data limitations) we cannot be sure that savings of comparable magnitude would not have been realized in the absence of ORT. This is an important qualification, since activities of the contractors began to increase substantially in intensity before ORT, in apparent response to earlier HCFA initiatives. In other words, *pre-ORT* initiatives are responsible

for some of the observed change in HCFA and contractor activity, so it is notably difficult to sort out what is attributable to ORT and what is not. It is in any event true that the activities of HCFA and its contractors played an important part in ORT, even if the incremental effects of these new activities cannot be estimated with precision.

5. Operation Restore Trust encouraged several important policy changes that were made during, or immediately following, the demonstration. Attribution of causal influence is complex, however. The existence of ORT resulted from strong beliefs at the highest levels of the federal government that more had to be done about health care fraud and abuse, and those same beliefs also prompted some of the policy changes. The focus of ORT on specific problem areas in specific states certainly helped build the body of evidence that led the Administration and the Congress to act — but so did the intensified efforts of the FBI and DOJ. While it would be an error to give full credit to ORT for the unusually active period of policy changes regarding fraud and abuse in 1996–1997, it also appears true that ORT made an important contribution to those changes.

   Thus, in certain relatively narrow examples — e.g., changes in Medicare rules affecting independent physiological laboratories and the compounding of medications — ORT was clearly the driving force behind the changes. Other, broader, and more important initiatives were certainly helped along by identifiable products and results from Operation Restore Trust, but the contributing factors are more numerous and diffuse. Examples are tighter control of DME provider numbers, the moratorium on new Medicare HHAs announced by the President in September 1997, the provisions in the Balanced Budget Act of 1997 to require surety bonds of some providers, and the new funding for anti-fraud efforts in the Health Insurance Portability and Accessibility Act of 1996.

6. We found evidence that ORT may have had important "sentinel effects" -- i.e., ORT may have deterred providers from certain kinds of suspect behavior. Using our standard double-difference model of ORT effects (i.e., estimating the differences in ORT states compared to non-ORT states and the pre-ORT period), we cannot say with confidence that ORT had sentinel effects, because the effects are not statistically significant at conventional levels. However, they are consistently negative (i.e., ORT was associated with a consistent decrease in allowed charges) for home health and DME outside nursing homes. The fact that they are consistently negative suggests that *something* important was going on, even if there is too much statistical noise for us to pick it up.

   During the ORT period, a whole array of government initiatives were implemented to combat fraud and abuse in the Medicare program. These initiatives included many efforts with nationwide impact (e.g., stepped-up enforcement efforts by the Department of Justice and the FBI, major HCFA initiatives with Medicare contractors, and others). These efforts contributed to a large nationwide decrease in allowed charges for home health and DME, and a smaller decrease for DME in nursing facilities. The models used to estimate sentinel effects do not allow us determine how much of the nationwide decrease in allowed charges was due to ORT spillover effects (i.e., effects associated with ORT on provider behavior in non-ORT states) and how much was due to other programs and time factors that would have occurred even in the absence of ORT.

7. We found considerable process effects in ORT. Specifically, we found:

   - The ORT partner agencies are collaborating more closely on fraud and abuse issues than in the past.

- Evidence of this collaboration is wide ranging and includes substantial initiatives between OI and OAS, federal regional officials and state agencies (e.g., federal and state survey staffs), regional agencies and Medicare contractors, and others.

- The integration of different skills on the same team—such as those of nurses and auditors—has been a major accomplishment of ORT, due in part to the presence of discretionary resources and in part to the philosophy of inter-agency engagement.

- HCFA contractors saw ORT as a positive influence on the work of the regions. But for these contractors, the big change of the past few years has been HCFA's restructuring of the program integrity functions of the contractors. In some cases, these restructurings have led to notable changes in carrier operations and (possibly by coincidence) notably active collaboration with ORT projects.

8. Giving AoA a fraud and abuse mission was a good idea and led to active training, outreach, and education efforts. But the effects of these activities on such outcomes as referrals and cases are not well measured, and key parts of the process (e.g., feedback of results to ombudsmen) are not yet fully worked out.

9. The work of OEI generally changed in only minor ways (e.g., reorientation of studies to include somewhat greater emphasis on ORT states and subjects). But ORT brought selected instances of more comprehensive and intensive studies that better equipped others for investigation and policy revision (as in the drug/nebulizer studies performed by OEI staff in the Philadelphia regional office). ORT also enabled one region (Dallas) to demonstrate an alternative role for OEI, bringing genuine in-house analytic sophistication to the targeting of enforcement efforts, notably through development of a major Medicare-Medicaid nursing home data base. Finally, the collaboration of ORT brought OEI central office more systematically into policy-making networks — from which OEI had been more distant than it realized.

10. The infrastructure of information for combating fraud and abuse has been significantly improved during ORT, although these improvements include many efforts outside ORT itself. The HCIS, the FID, and other information systems and computer resources will provide important capabilities that were not available before. Meanwhile, new estimates of the prevalence of fraud and abuse are being developed. Specifically, as required under the Government Management Reform Act (GMRA) of 1994, OAS has completed a major audit of Medicare claims to provide an estimate of the underlying rates of improper payments (improper payments include fraud and abuse, but also insufficient documentation and other problems). GMRA requires this audit to be performed annually. The availability of annual estimates of improper payments will make it easier to determine underlying trends in fraud and abuse, to establish more definitive sentinel savings for enforcement efforts (estimates that take into account provider responses), and to establish more data-driven allocation of enforcement energies. Such information would be a major step forward.[61]

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61 It is important to note that, at some point, if government enforcement efforts have sizable deterrent effects, the level of fraudulent activity should decline, and with that decline, there might well be a decline in the number of cases being brought. The best way to know why that decline had occurred would be through analyses of time series data on improper payments, such as OAS is developing. Without such data, there would be no way to know whether the decline in cases was due to lower rates of misbehavior by providers or less effective enforcement methods by the government and its contractors.

11. ORT included a series of national initiatives not exclusively confined to the ORT states: an enhanced OIG hotline, a new Voluntary Disclosure Program, and wider use of special fraud alerts. Each of these initiatives makes sense as part of a modern program integrity effort. However, none of these initiatives was crucial to the effects of ORT.

On balance, this list of effects is a record of substantial accomplishment. It is too soon to say what the ultimate benefits will be from ORT. Exhibit 34 in Chapter 10 summarizes what we believe can be stated at present about the relationship of costs and monetized benefits in ORT. Obviously, there is considerable uncertainty about key results. But beneath all of the qualifications and data limitations noted on the exhibit and in the report that follows is a story of substantial success. At a minimum, as we noted in Chapter 10, the savings from OI cases alone may well cover ORT costs many times over; and the savings from other sources are also likely to be substantial: i.e., from OAS audits, HCFA and contractor activities, policy changes, and sentinel effects. The fact that we are unable to estimate savings from all of these activities does not mean that we expect zero savings in each case. Indeed, the results are likely to be positive in each case and are potentially quite large. Thus, even using fairly conservative assumptions — and even at this early date in the maturing of cases, audits, and other key activities that will actually produce the savings — we expect the savings from ORT substantially to exceed the costs.

While it is too soon to offer definitive estimates of the savings attributable to ORT, it is fair to say that information now available documents results that most ORT partners would have welcomed in the beginning. To most observers — excepting significant portions of the provider community — ORT has been a notable success. Indeed, that result has been formally asserted: the Secretary of DHHS has announced the extension of ORT methods nationwide, with an initial focus on 12 additional states. In addition, DHHS anti-fraud efforts received major new resources and enforcement authority in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and additional enforcement powers in the Balanced Budget Act of 1997.

We generally agree with the favorable appraisals of ORT — indeed, in areas like our sentinel estimates, we believe that the general consensus might understate what ORT (in combination with other government initiatives) has accomplished. The challenge for the future will be to sustain and enlarge these accomplishments. This challenge is important because, in our judgment, *the considerable accomplishments of ORT were achieved under very special circumstances*, including:

1. Focus on a few states and a few areas of the benefit — Rather than attack fraud and abuse in a broad, undifferentiated way, ORT contained a set of deliberate limits (most important, five states and three fast-growing areas of the benefit). ORT opted for high impact in a few areas, rather than risking slight impact across a larger canvas. It will be a challenge to maintain the advantages of such focused efforts, now that ORT is being expanded and extended.

2. An infusion of resources — ORT provided a special infusion of financial resources that gave ORT regions more discretion to pursue promising activities. In addition, in a move technically separate from the ORT budget, DHHS increased investigative staff in the ORT states by 43%, along with certain other OIG staff additions. These added staff resources were important to what ORT accomplished.

   After most demonstrations, it is difficult to sustain the special increases in spending (and other resources) that the demonstrations brought — especially when the demonstration is, as here, being expanded. But after ORT, under the new arrangements authorized by HIPAA, resources should be available to support an expanded effort to identify and investigate health care fraud and abuse.

3. More active collaboration — Under the "partnership" approach of the ORT demonstration, ORT encouraged the partner agencies and others to collaborate actively and informally, rather than in the more isolated, sequential ways of the past. This encouragement was backed by ORT resources, high-level attention, and other means. While no one can measure the gains from collaboration in any precise way, everyone saw collaboration as a key to ORT accomplishments. We were offered innumerable small and large examples of how such collaboration improved the work of each of the agencies.

   It will be a challenge to maintain this collaboration after ORT is over. Both headquarters and regional staffs say that old ways of doing business cannot return, because ORT (and their own considerable experience) has shown that those old ways do not make sense. Indeed, planning efforts for HIPAA and ORT continuation were more collaborative than pre-ORT efforts. But these planning efforts were not as clearly collaborative as ORT itself. The struggle to keep barriers low among the partner agencies will be a continuing struggle and will require extensive continuing efforts at all levels of DHHS. The outcome of that struggle remains to be seen.

4. High-level attention and the "ORT priority" — High-level attention was a fundamental part of the energy behind ORT, and an important reason that bureaucratic walls could be lowered. The demonstration was announced by the President, overseen by the Secretary of DHHS (through her Chief of Staff), and managed by a Special Advisor to the HCFA Administrator for Program Integrity. High-level oversight meetings were held bi-monthly (later quarterly) among the partner agencies, under DHHS auspices. Regional ORT teams met once a month (typically by teleconference) with the Special Advisor, who was in a position to withhold ORT funds from regions that failed to develop satisfactory plans. In view of all of these different avenues of pressure and visibility, it is not surprising that one could get immediate attention for an ORT-related project by simply making the ORT relationship known.

   Now that ORT is over, there is still considerable high-level attention, but it will be a challenge to maintain this kind of priority. The extension of ORT must mean some reduction in the focus that was important to the accomplishments of the demonstration. At the same time, in HCFA at least, oversight of these activities has been moved down in the organization, although (as part of HCFA's more general reorganization) the Special Advisor does have dotted-line reporting authority directly to the Administrator. Meanwhile, the frequency of high-level oversight meetings among the partner agencies has declined — something that was bound to happen, if for no other reason than that scarce high-level attention would have to be spread among an expanded set of regions.

   In thinking about the likely effects of these changes, the experiences of the comparison regions we studied are instructive. Staff in these non-ORT regions have attempted many thoughtful initiatives. In the words of the staff responsible, such initiatives are feasible even without ORT-style priorities. But in the absence of some means to prompt immediate attention, these non-ORT initiatives have required extended effort to accomplish simple things—e.g., to get a contractor and a state agency together to pursue some kind of data match. That is the kind of difficulty that ORT seems to have solved. The ORT priority cut through ordinary inertia. The challenge after ORT will be to maintain the sense of urgency ORT succeeded in creating.

5. A set of reinforcing initiatives by other agencies — ORT did not exist in a vacuum. ORT efforts were supported and reinforced by a whole array of government initiatives,

including HCFA initiatives with Medicare contractors (establishment of the DMERCs and the specializing of program integrity contracts), new powers in legislation from Congress (e.g., HIPAA), major DOJ initiatives (e.g., expansions of health care task forces and funding of Assistant U.S. Attorneys specializing in health care fraud cases), and others. These generally complementary efforts had important effects on what we observed for ORT.

Most important federal actors in this process have made commitments to give health care fraud and abuse a continuing high priority. These commitments will be needed to support future activities along the lines of what ORT achieved under exceptional circumstances.

We believe that the accomplishments of ORT can indeed be extended and expanded in a form approximating what ORT itself accomplished. Many of the preconditions for continued success are in place — most importantly, in terms of funding, personnel, and new statutory authority unthinkable even a few years ago. The key questions now concern whether 1) an expanded effort — for all its virtues — will lose the advantages of refracted attention, attention that will now be dispersed across a broader area, and 2) whether the continuing commitments in DHHS and elsewhere will suffice to keep bureaucratic barriers down, so that agencies that are extensively interdependent in principle will continue to collaborate extensively in practice.